MENTAL HEALTH PLANNING FOR SOCIAL ACTION

How to make the most of our knowledge and facilities for promoting better mental health

George S. Stevenson, M.D., Sc.D.

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Department of Health, Education and Welfare
National Institute of Mental Health,
and Veterans Administration

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"There is more scientific knowledge and technique for dealing with mental illness than is now being used." This is the challenge Dr. Stevenson presents.

How we *can* use our current knowledge to a fuller extent and toward better results is set forth in this thorough and wide-ranging book. The goals of a mental health program—ways to find the mentally ill—the need for classifying them—are laid down as the cornerstones of a dynamic, constructive mental health program.

Dr. Stevenson examines the mental hospital and makes constructive suggestions about how it can increase *its* contribution to mental health. He gives test questions for a hospital's success, tells why the clinic should come under the immediate authority of the hospital, suggests how the mental hospital can attract more personnel, shows how to use volunteer service for public education.

The place of the government in mental health—County, State, Federal, and the Veterans Administration—is clearly shown, *with* suggestions as to which government division can best perform each service. In addition the church, school, prison, industrial firm, military defense services and other institutions are all assessed as to their present and future contributions to mental health. What can be done for the child, the delinquent, the criminal, the aged, the mentally deficient, are also problems included in the wide scope of this volume.

To enable those concerned with mental health to make the *most* of existing facilities and to work closely with other groups toward common goals, this book offers many new perspectives.

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For Social Action

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FOREWORD

One of the distinctive features of our present civilization is our dependence upon an active, vivid interaction between government, private agencies, and individual voluntary activity. When any three English-speaking people develop a concern on any subject, they are more apt than not to form a committee to do something about it. No subject is too esoteric, no issue too grandiose or too remote, for citizen attention. The mental health movement is an outstanding example of this tendency to take responsibility within a steadily changing society. As increasing knowledge in medicine and the sciences has given us a glimpse of a world in which it is no longer necessary to accept mental ill health as an inevitable tribulation, to be borne patiently, citizen efforts to institutionalize the new insights of hope are developing all over the world.

Parallel with such a development there comes a demand for a new kind of wisdom, the wisdom of those who have watched the birth pains of a new movement, the struggles of the young societies to get on their feet, the periods of crisis and choice, the agonies of mergers, and the finality of death, as some cherished program item becomes definitely nonviable. Such wisdom and experience is hard come by, it has to be lived, and it takes many years. Such wisdom is gained by those who must struggle with the brilliant vagaries and inspirations of the original prophets, who must learn to translate visions into programs and patterns of organization. It is won only at the cost of millions of hours in conference, on committees, hours of patient, unremitting struggle to convey to one group of people what one has learned from the successes and failures of another group.

It is such a distillation of attention which George Stevenson brings in this book to all those who would wish to have him on their committee, in a world where there are now too many committees, clinics, conferences and societies, agencies, local, state, national, and international, for even his dedicated capacities to encompass. Chapter after chapter of this book takes up, with quiet, undramatic thoroughness, the issues, the questions, the practices, and the plans which citizens, young professionals, and young government specialists need to know about as they work in the developing field of mental health.

And this distillation is disarmingly quiet and unsensational, yet written with a clear recognition of human frailty combined with compassion for human weakness. So, he remarks: "Group planning often becomes confused because different members of the group try to deal with different issues at the same time. But the ease and simplicity of planning by one person is the result *in part* of the limitation of his grasp" (italics mine). Or take the two sentences describing someone who limits his attention to Western Europe and North America, who would "be impressed with the progress of civilization but he would also be misled. He would be impressed with the rapid expansion of concern for the mentally ill in 150 years. He would be misled unless he discovered that most of the world is today not as well equipped as this part was 150 years ago."

Here speaks, as quietly as he has lived, the man who has done more than anyone living to advance the cause of mental health in the United States. As one who has lived through stormy sessions, attacks of doldrums, tense moments of redefinition of the undefinable, and crises in which the death of all our hopes seemed imminent, always thankful that George Stevenson was there to see the pitfalls, develop a compromise, invent a solution, or simply make us more human again with his own unfailing humanity, I am grateful that he has put down on paper the kind of insight on which the mental health movement has thrived and broadened until it circles the globe.

Margaret Mead

PREFACE

Teachers and practitioners in special areas of the field of mental health have challenged the author repeatedly over the seemingly boundless range of the field. They are not alone in this quandary, for members of boards of mental health associations, service and promotional agencies, legislators, and students of the medical and social sciences are puzzled by the same thing. On the other hand, the breadth of the field of mental health is not surprising, since it is concerned with the way people live, and people do "cover the world."

The intended audience of the book consists of all who work and plan for mental health. It is hoped that the book will help them to achieve a perspective on the whole field—the common threads that run through it, and the interrelationship and interdependence of its parts—thereby enabling them to do more for mental health. That they will be able to work in a team with others whose role is different from their own—this is the goal. The scheme is to present some suggestions on program planning, to follow this successively with chapters on program content as it relates to the restoration, the protection, and the elevation of mental health, and finally, to present suggestions bearing on program execution.

The contents of the book constitute the message. The book itself is the channel of the message and therefore meets the requirements of an educational effort, as discussed in its final chapter on program execution and in the paragraphs dealing with education as an instrument. Its goal, audience, message, and channel are specified.

While in this instance the channel is a book, the same message has already been conveyed many times by the author to other audiences over other channels: reports of surveys, lectures to university classes, and consultation with individuals or groups who are planning new or better services under Federal departments or in local communities. The message has been included in advice to mental health associations and courts and in testimony before legislative bodies. It has appeared in the transactions of conferences, in annual reports, in formal and informal presentations, over the air, and in letters to the press.

If one is to hold his distance from an objective far enough to achieve a perspective, he must sacrifice detail. If he happens to have knowledge of the detail, he is tempted to describe it. Consequently, the distribution of detail will be uneven in this book. The author already knows from comments on the manuscript that many details are omitted. To have satisfied all predilections in this respect would have carried the task beyond the reasonable confines of a single volume. By way of compensation, he has given abundant references which are intended to start the reader off in any specific direction he may choose. The student, especially, may thus begin his approach to the field of mental health with an appreciation of its parts, interrelationships, and processes.

It is equally true that this message, through varied channels, has been brought by others to the author, who has become the audience and had his perspective broadened. In fact, it was one particular friend and colleague, Dr. Julius Schreiber, of Washington, who prodded the author to undertake this task and gave him invaluable advice and criticism in its execution.

Help was given on specific chapters by others. Dr. Harvey J. Tompkins of the Veterans Administration and several of his staff, Brig. Gen. Louis H. Renfrow of Selective Service, and Dr. Morton A. Seidenfeld of the National Foundation for Infantile Paralysis were especially helpful. Within the National Association for Mental Health, the burden of transcription and incidental critique has been carried by the author's secretary, Veronica Higgins. Isabel Johnson and Anne E. Stevenson gave literary help in some of the more difficult chapters.

A major source of encouragement behind the "spelling out" of the author's perspective has been the interest of some of the larger foundations in supporting pathfinding mental health projects. In particular, the interest of the Rockefeller Brothers Fund has been a real incentive.

George S. Stevenson

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PART ONE

Basic Considerations

1 INTRODUCTION—MEANING, RANGE, HISTORY, AND AGENCIES

It is nearly fifty years since Adolf Meyer suggested to Clifford W. Beers that he adopt the name *mental hygiene* for his new movement which aimed to advance mental health. But there is still uncertainty as to what mental health means. Uncertainty may never be entirely removed, but the fuller the understanding of mental health, the more direct will be the guidelines to advancing it. So one may well ponder on the question: What is mental health?

MEANING OF MENTAL HEALTH

What is that quality which is the therapeutic goal of those who treat the mentally ill? What is it that a preventive mental hygiene attempts to preserve? What is it that a positive mental health agency tries to build to a higher level? The easiest answer is that it is the absence of mental illness. This answer may be useful, though hardly adequate. It, of course, narrows the problem, for there is no difficulty in excluding large areas of pathological human behavior from the range of mental health. A part of understanding is to grasp what a phenomenon *is not,* as well as what it *is*. It also helps to know what mental health is *a part of* or *related* to. A useful answer to a question must also take the purpose of the question into account. The meaning of mental health for research purposes must be more exacting than its meaning as a goal in practical operations. For example, if one were to try to employ personnel with ideal mental health as a qualification, he would employ no one. If a psychiatrist were to set absolute mental health as his goal of treatment, he would have no recoveries. Similarly the educator, the psychologist, the public health expert, and the social worker all accept health as a relative or practically effective but not perfect state, and under this principle they find their efforts rewarding. They aim for a degree of mental health that reflects the lot of more fortunate humanity. This the World Health Organization has referred to as "a state of well-being."

In terms of behavior it is still worth while to know what the earmarks of better mental health are. What is "well-being"? At this point the sociologist and cultural anthropologist offer a warning not to describe mental health the same way for the whole world. Behavior that may cause no concern in one culture or one family may be a signal for alarm in another. *Mañana* can be wholesome where the rest of life and the community are adapted to it. *Mañana* in another setting may be an unhealthy retreat, reflecting mental ill-health and an aimless life. Consequently a world organization representing a great diversity of cultures was wise in not trying to be more precise than to identify mental health with well-being.

In any case, mental health or ill-health is reflected in the things that people do, and it is roughly measurable by observing what they do in relation to the world about them. Can they, for example, derive inspiration from the differences between people, or are their capacities for adjustment so narrow that they cannot be comfortable or effective when conditions and customs change a little? Do they help other people to feel comfortable and to continue to develop in their own ways? Do they assess the world about them reasonably accurately, or, on the other hand, deceive themselves? Do they tackle the task at hand, or do they evade problems? Are they able to accept their own mistakes, failures, and limitations, or must these be made to appear nonexistent or the fault of others? Are their faculties of memory and recognition of time, place, and persons blurred or reasonably clear? The behavior of a mentally healthy person is well described by Schreiber:[1]

> When we find such a fortunate person, we find that he reacts to the world on a realistic basis—not as he imagines, fears, or wishes it to be. He may like or not like what he sees; he may accept the way things are or he may act to bring about change; but in either case, his feet are on the ground. He has learned how to profit from experience; knows that there is a wholesome and acceptable difference between unattainable perfection and a reasonably good score; and hence, can contentedly accept a ninety per cent rating when the price for trying for perfection is too high to pay.
>
> Our lucky friend knows how to love on a mature basis where giving to

> others and doing for others is more meaningful and gratifying than receiving for oneself. Also, he has developed the knack for taking the hard tumbles in stride—even if the strides have to be a little bit shorter and more cautious. While he is a mature person and exercises a reasonable amount of aggression, he does not foolishly pretend or strive to be a tower of strength exclusively unto himself. He quite readily leans a little, in healthy fashion, on some of his fellow human beings.
>
> Further, our emotionally mature (or mentally healthy) individual has learned the trick of being quite honest with himself. From time to time he critically re-examines his values—all of them—to see if they can stand up under the careful scrutiny of newer experiences and newer information. He understands and accepts adult values, steadily giving up infantile notions and prejudices as being unworthy guides for adult conduct.

These are just a few signals of the state of one's mental health. But most of them are *only* signals. One's mental health itself is largely a matter of one's habitual attitude toward himself. Again quoting Schreiber,

> Healthy living—or mental health—means that an individual has found a reasonable measure of peace with himself and with his environment. It means that an individual is able to pursue reasonable, purposeful goals; may use his capacities and talents fruitfully; experiences a sense of security, of belonging, of being respected; has a knowledge that he is liked or loved and wanted; has a sense of self-respect, of self-reliance, and achievement; and, in addition, has learned to respect others, to accept others, to love others, to live fairly and in peace with others.

The outward signals reveal one's attitude. They are generally reliable, but not always so, for sometimes they magnify relatively unimportant underlying attitudes. This happens in cases of serious physical illness such as a toxic condition in an acute infection. This may render a person grossly psychotic (delirious) and magnify or reveal attitudes that a short time before were insignificant. Drugs such as lysergic acid have been used to produce these exaggerated signals of mental ill-health experimentally. In brief, then, mental health acquires meaning only as many variables are taken into account. Brief definitions are bound to be misleading.

THE RANGE OF MENTAL HEALTH

An appreciation of the range of mental health also helps to give the term meaning. In a strict sense every aspect of life affects mental health. To deny this would be a violation of the principles of integration.

The Wholeness of the Person. This principle is basic to healthy human functioning. It means that, when a person behaves, he behaves with every part of him or wholeheartedly. Academic and professional disciplines and departments may seem to compartmentalize human functions rather neatly. But in real life people do not function separately at home, at work, at play, and at church. Man resists fragmentation. Professions are most effective when they help a man to function as a whole. In fact, the enduring leaders in every discipline have become leaders because they see all human functioning as a continuum and they see their disciplines as partial approaches only. In applying their knowledge to human problems they know how to relate their work to the work of other fields.

Some experts fail because they work in isolation and leave it to the recipient of their services to reconcile interprofessional differences. Far from being an onerous obligation, however, the rendering of his services in fuller perspective gives to the work of the inspired professional more zest and fuller meaning. For example, the heart specialist who concerns himself with the joys and fears, the family life, the friends, the play, and the work of his patient finds more meaning to the behavior of a heart than if his approach were limited to a chest examination and some mechanical and chemical tests and a routine set of questions. With a more limited approach the irregularities in the behavior of the heart that are brought about by emotions are frustrating and meaningless inconsistencies. Thus one can pay attention to the wide range of man's functioning while still focusing on some partial aspect if he constantly observes that he is dealing only with a part and that that part is never independent.

Mental ill-health is failure to function as a whole. Those professions that deal with disturbance and deviations in human behavior know well how disastrous can be the failure of man to behave as a whole when he is mentally sick. It is dramatic to see this disintegration in the case of amnesia and dual personality of the Jekyll-Hyde type, or in the shattering of personality into fragments in cases of schizophrenia. But it is in the aggregate a greater loss when this disintegration reduces a relatively normal man's potential less dramatically through bad judgments, confused loyalties, indecision, and—perhaps most serious of all—love mixed with doubt and hate.

Imperfect Appreciation of the Range. Any sound effort to describe the range of mental health must be governed by a perspective that is as broad as human living. It must recognize that at best the perspective will be only partial, such are our human limitations. It must be sure to leave many unfinished edges to the picture, as it is never fully appreciated, and it must allow for expansion later. It must recognize that the field as seen by one person will differ in both its center and its limits from that as seen by others.

Since every aspect of life bears on mental health, so all agencies that deal with the lives of people have some impact on mental health. But, of course, it is impossible to include all agencies in this book, both because the author's perspective is limited and because the size of a book must be limited. The chapters that follow deal only with those agencies that exist more expressly for mental health or are highly important to mental health. Some of these agencies claim a large territory, but actually work in only a small part of it. A person concerned with the advancement of mental health does well to select activities of top priority to absorb a large portion of his effort and resources. But it helps him to maintain a balance if a portion of time and effort is reserved to cover any other aspect of the field, to seize exceptional opportunities, and to deal with emergencies. The same is true of an agency such as a mental health association. This is the guiding principle of program planning as discussed in Chapter 2.

CONNOTATIONS OF MENTAL HEALTH

So much, then, for what mental health *should* mean. It should mean the absence of mental illness. It should mean psychological freedom that allows one to get on with others and to cope with life as demanded by his own society, but it should also mean the ability to be comfortable in the face of different cultures and customs. It should mean the ability to make reasonably sound judgments, to have a fairly accurate memory, and to be well oriented. It should mean something broader than one person can usually fully grasp, because it has to do with all aspects of life. These are the things that mental health *should* mean.

But what *does* "mental health" mean to people? This is revealed in literature and in the aims of most of our social institutions. The term *social institutions* is applied to those well-established customs and practices that give society its character. These include such things as protection of the family, education of children, and the care of the sick. Some of these practices are performed by institutions in a different sense, i.e., formal agencies.

We find that man strove for mental health long before the term was invented and that he was ready to adopt the term and give it meaning when it came along. There is a widespread and long-established understanding that the ways in which people think, feel, and act are at times good and wholesome and at other times the opposite. The chapters which follow deal with our social institutions. They show that while mental health means something of great value, the struggle to advance it has to contend with a distaste for thinking about mental illness. This distaste blocks progress. There are some who claim that society needs a category of pariahs such as the mentally ill and criminal, so distant from the normal as to overshadow the little deviations from mental health that everyone has and tries to hide. In this sense society's stigmatizing reaction to the mentally ill is itself a problem of mental ill health.

It is not surprising that the term mental hygiene was first applied (1908) to an effort on behalf of the mentally ill and that many can still define mental health only as the absence of mental illness, for mental illness is the most glaring problem of mental health.

If one were to limit his study of man's efforts on behalf of mental health to the vast medical, educational, and welfare facilities that exist today in Western Europe and North America and trace them to their beginnings, he would be impressed with the progress of civilization, but he would also be misled. He would be impressed with the rapid expansion of concern for the mentally ill in 150 years. He would be misled unless he discovered that most of the world is today not as well equipped as this part was 150 years ago. He would also be misled unless he looked more critically at the present facilities of his own civilization. On the whole they offer little to his pride in that civilization. Its mental hospitals are, as a rule, not really hospitals but rather habitations euphemistically called hospitals. In every field of mental health, society even at best fails to use what science already has to offer.

STRIVING FOR CIVILIZATION

It was because of this failure of man to live up to his concept of himself as a civilized being that we find a procession of social reformers. Some of these tried to help society to be civilized toward the mentally ill. Others focused on the mental health aspects of education of the young, punishment of offenders, and help to the poor. Pinel in France, Tuke in England, and Dix [2, 3] in the United States are three that stand out for their efforts to civilize their countries on behalf of the mentally ill. The need was clear, and society's failure stirred them to action. It took very little imagination to plan better treatment for the mentally ill. But it did call for aggressive action to change public attitudes.

These pioneers all left their imprint on the mental health field. However, depending on the timeliness of their efforts, there was always some retrogression after their passing, because society was never relieved of its revulsion. This regressive tendency with the passing of leadership is one of the great lessons of history to be recalled as a warning whenever rapid progress occurs. The gain sometimes amounts only to a greater public awareness of a problem. One learns, therefore, to pay attention to timeliness. This means paying attention to whether people have reached a point where they are ready to modify old ways of doing things. If they have, then effort can be conserved or strengthened by taking into account that readiness to change. Sometimes an advance is timely because there has been a change in values, such as the development of belief in the intrinsic worth of people. Sometimes it is because science has advanced to the point of assuring better results. Those who have devoted their lives to social change know that when an advance shows diminishing returns its timeliness is running out. The meaning of mental health, therefore, varies with changes in the times.

Clifford W. Beers, as a former recipient of society's grudging service to the mentally ill, had no reservations as to their need of a sponsor. In 1908 as a result of his effort [4] there was established in Connecticut the first agency designed to advance mental health in general and to concern itself with all aspects of the field. The next year a similar agency on a national basis was set up, and twenty-one years later an international organization was begun. While these organizations were at first concerned with the mentally ill, their efforts soon spread to such aspects of mental health as immigration, penology, education, and child-guidance clinics.

MENTAL HEALTH ORGANIZATION

The mental health association is a significant if not unique social phenomenon. It is a partnership of those who care to be concerned with mental health. It thus helps to change for the better the meaning of mental health, advancing it in a positive direction. It reflects the acceptance by the citizen of two responsibilities that are essential to a civilized democracy. The first is that all citizens in a democracy are the government and have an inescapable political responsibility for it. Today the citizenry has in this political respect only partially matured. The second is the moral responsibility of each human being for those others who cannot meet their own basic needs.

But citizens who have matured in these two respects are often ineffective because they work alone. The mental health association provides the strength of numbers. It differs from the professional society in that it includes both lay members and representatives of all the professions concerned with mental health. It is thus a citizens' agency rather than a lay or professional group. It selects its activities on the principle that whatever is appropriate for a citizen to undertake is appropriate for a group of citizens. It has at its disposal many kinds of technical leadership within its ranks.

Just as the average citizen is not competent to make professional judgments, so the mental health association depends for standards of personnel and good practices upon professional associations. It is hard for some people to accept the expert in mental health or in the deviations of human behavior. To them mental health simply means common sense. It is true that everyone, having grown up with people and lived all his life with them, knows much more about their behavior than he does about other technical matters, including their physiology. On this account it may be harder for him to accept the science of human behavior than other sciences.

Special Hazards. A mental health association is in principle comprehensive. But, as has been previously pointed out, no one appreciates the full range of mental health. At present, therefore, programs are formulated without any effort to weigh the needs to determine priorities of the whole field. They are laid out on the basis of a "feeling" or a bias as to what is important. The ensuing chapters on the process and content of programming should give to mental health a more comprehensive meaning. It should aid professional associations and public agencies as well as voluntary citizens' associations in designing their work. In fact, it may serve other fields as well as mental health.

In spite of opportunistic programming, much good work has been done. The smallness of the programs has made it easy to "skim the cream." But the programs have been too narrow. For example, school authorities can be induced to extend their curricula to provide for the mentally deficient. But unless something is also done to improve the conditions into which the mentally deficient individual must fit later in his community, the curriculum is not based on the kind of social, occupational, and domestic life that he will have to lead.

Another result of this piecemeal planning is that the program is concentrated on one group or profession and fails to achieve interprofessional understanding. For example, a clinician who was asked to evaluate a project designed for the mental health education of teachers judged the project only as a therapeutic process and thereby distorted its positive mental health meaning.

Conversely, those who are more concerned with the mental health of normal persons sometimes protest that a program focused on the needs of the mentally ill is outside the mental health field. They apply the term "negative" in a derogatory way to such a program, and "positive" in an approving way to a program designed to improve the functioning of normal individuals. The failure of each to see his task as a part of a larger whole has accordingly resulted in conflict between professional groups who have everything to gain by working together.

Mental health has a very special meaning for those who have, like Clifford Beers, experienced mental disorder. Citizens' organizations exist for many other parts of the health field such as tuberculosis, cancer, and heart disease. All these citizen health agencies tend to attract to active membership persons who have come close to the illness covered by the organization. For example, the person who has suffered a heart ailment may express an interest in research and increased service for heart ailments. Similarly many who have been close to mental illness become active in a mental health association. Much of the most energetic and effective leadership has come from such persons. Clifford Beers is the outstanding example. But this tendency presents a special problem in the field of mental health. There the elements of interest, aggressiveness for action, etc., fall functionally within the area of the disability. An emotional difficulty may seriously handicap a person in wisely exercising interest and aggressive action. This is not a common problem, but it is serious when it exists. It calls for careful planning so that each person may be given an opportunity to use his assets and not suffer defeat at his own hands.

CONCLUSION

It may be evident by now that the meaning of mental health is not revealed by a definition. It is acquired rather by approaching mental health from various angles: behaviorally, genetically, and in terms of citizen responsibility.

NOTES

1. Schreiber, Julius: "Mental Health Flowers in Democratic Soil," *Mental Health Bulletin,* Illinois Society for Mental Hygiene, 29:1–3, March-April, 1951.
2. *American Journal of Psychiatry,* Centennial Anniversary Issue, 1944.
3. Deutsch, Albert: *The Mentally Ill in America,* 2d ed., Columbia University Press, New York, 1949.
4. Beers, Clifford W.: *A Mind That Found Itself,* 5th ed., Doubleday & Company, Inc., New York, 1921 (reprinted 1953 with additions).

2 PROGRAM PLANNING

In Chapter 1 it was pointed out that mental health programs are often laid out on the basis of "feeling" or bias. The dilettante may legitimately pursue a mental health interest in a fancy-free manner. He may sense a challenge and be led by it into whatever channels its ramifications follow. His responsibility is to himself. If, however, advancement of mental health is in hands to which the public looks for leadership and which it supports, careful program planning is an obligation. Planning is not only insurance that the product of effort will coincide with objectives of the group. It is also insurance that the goal will be approached most quickly and economically.

GOALS OF SOCIAL ACTION

Most persons who are interested in mental health tend to restrict their interests and activities to specific limited aspects of the total field. Only the citizens' mental health association concerns itself in principle with the whole field. But even that agency must restrict its effort and discriminate in designing its program because its limited resources force it to set priorities. Those who are concerned with mental health express their objectives in one or more of the following three goals:

1. The restoration of mental health
2. The preservation of mental health
3. The elevation of mental health

It facilitates planning to be clear as to which goal is being pursued and to be clear as to the meaning and implication of each goal. Chapters 3 to 14 deal with agencies directed mainly toward the first. Chapter 15 deals with those that are preventive, and Chapters 16 to 22 with positive mental health.

In the planning of a mental health program each of these three goals is so broad that it can serve only as a very general guide. It is necessary to scrutinize these goals closely in order to determine how the efforts to reach them may be divided and to establish priorities. Who are they whose mental health needs to be restored? Where are they, and through what agencies are they to be helped? Whose mental health is threatened to the point of needing protection, and by what agencies are they to be protected? Whose mental potentialities are undeveloped, and what are the means by which society tries to serve them?

General criteria for establishing priorities are presented in this chapter, but specific detail about those who need attention and what society is doing for them occupy subsequent chapters.

DEFINING SCOPE

The first step in planning program is the clarification of the framework within which the program must be carried out. An organization's objectives are apt to be stated in its constitution, charter, or authorization. If the organization is not specifically concerned with mental health, it may need to spell out the part of the field to which it can appropriately devote itself.

Those who plan do well to take into account what kind of an organization they are working for. It will make a difference whether it is a voluntary citizen, professional, or governmental organization. A general citizens' mental health association has a wide range but also certain limitations. It has not the authority to enunciate a professional consensus, such as qualifications of personnel. It may, however, be forced to set standards when a profession fails to do so. A professional association is also limited. It acts appropriately only within the limits of its professional scope. For example, a professional association may authoritatively criticize the technical content of a radio program but not its dramatic quality. A state educational association lacks authority in respect to the problems of the state hospital, although it may appropriately concern itself with the institutions for mental deficiency whose functions tie in so closely with those of the schools. A psychiatric association is not apt to claim authority in the selection of teachers, though it may collaborate with educators in this task.

The scope of a program is determined also by the conditions attached to its creation and financial support such as dues, private contributions, and tax funds. A department of public health in the United States seldom is authorized to care for the mentally ill. Its interest in mental health is usually preventive. However, in Canada the administration of a provincial mental hospital is within the commission of a ministry of health.

THE POTENTIAL PROGRAM

Later chapters on the content of the field of mental health offer a wide range of choice from which a program may be planned. No agency will encompass all these areas. Some will be outside the agency's purposes, some will be peripheral to them, and others will be central to them. The peripheral and the focal areas make up the *potential program.*

It is helpful in program planning to have the potential program spelled out. Normally an agency would choose to concentrate on or begin with more central issues. But sometimes strategy will force it to include in its program less central tasks in order to open the way to a task that is more focal. This is apt to be the case where remote causative factors or early stages of a problem offer better promise of getting into action than a direct attack. For example, the preventive attack on general paresis may be encouraged by a mental health agency, but it is not carried out within psychiatry or even within the field of mental hygiene as usually conceived. It calls for the prevention of syphilis or its early and effective treatment before the spirochete has become entrenched in the brain. Such prevention is a function of a public health rather than a medical program concerned with the restoration of those who have already fallen ill.

The potential program also serves as a guide in making community mental health studies and surveys. The object of a survey is to understand the present state of affairs with respect to each part of the potential program, including the potential allies or obstacles. A survey also includes a review of existing knowledge and the possibilities of action.[1] It produces facts which allow of the application of criteria of priority. Further discussion of surveys will be found in Chapter 23.

But a survey has also a less obvious value. A person cannot participate in a survey and study without becoming an exceptionally informed citizen, capable of giving leadership beyond that which would be expected of the average. He becomes a valuable community resource in carrying out program.

CRITERIA

The potential program along with the facts obtained by study and survey provide the materials from which program is constructed. To this end the various elements of the potential program are weighed in order to arrive at priorities. The use of certain criteria is helpful in weighing the relative importance of potential undertakings.

The employment of a set of criteria for this purpose may appear to be a methodological innovation. Actually only the spelling out and organization of the criteria are new. Criteria are used in any thoughtful programming, but sometimes they are used unconsciously or informally. Sometimes criteria are used without recognizing what they are. What is called "opportunism" or "expediency," for example, may be really a respect for one of these criteria, i.e., the readiness of the public to act and to support action. However, where this criterion is recognized one may count more realistically upon public appreciation, participation, and backing.

The criteria are best formulated as specific questions that can be applied to any problem or line of action. These questions help to broaden the base for a choice and to challenge biases. The facts and understandings gained from answering these questions also can be used to improve the strategy of action. For example, in promoting the development of psychiatric services in general hospitals it is important to find out by preliminary studies where the opposition lies. Is it the trustees, the staff, the patients, or the public generally? In short, who are the allies, who the opponents, and who are indifferent? What are the reasons for their attitudes, and wherein do they agree and disagree?

The six criteria presented below do not cover all important considerations. A careful study of a problem or project may call for added questions. Also any one criterion will vary in importance from case to case. However, the answers to these six generally significant questions are apt to weigh very heavily in a final decision. If, having used them, one feels in disagreement with the dictates of these criteria, he has a clear warrant to look for the reasons for his feelings and inspect their significance. In this sense the use of formal criteria is a check and not a substitute for subjective or intuitive judgments. Feelings as to what is important are still worthy of attention.

The chapters which follow are intended to help in the application of these criteria. They should facilitate program planning and identify some of the realities that will have to be taken into account in program execution. The six proposed criteria have a twofold applicability. They may be applied to any sector of the field in order to measure its relative call for action. They may also be applied to any proposal or plan of action to meet a need in order to test its relative importance and validity.

The six criteria which have been found useful in arriving at priorities are:

1. Is the problem or the project appropriate to the purposes of the organization? Specifically, is it a mental health matter?
2. Is it serious to the persons affected?
3. Does it affect many persons? Is it frequent?
4. Does it affect society significantly?
5. What is the extent of knowledge, equipment, personnel, and techniques available to attack the problem or to execute the project?
6. What is the attitude of the professional and lay public, including their readiness to provide support or to obstruct?

Criteria cannot be reduced to numerical values as a measuring rod. They cannot be expected to result in a final score which will indicate relative importance. They are rather a way of subdividing judgments in such fashion that specific considerations can be given to each part. They help to reveal obstructions which might pass unappreciated without this analysis.

Criterion 1—Appropriateness. The appropriateness of the problem or project for inclusion in a mental health program is relative, for *in a strict sense any proposal that affects human living affects mental health.* Therefore, it is well to evaluate a problem or project in relation to a central interest. Is it near the heart of this interest or near the fringe?

A general mental health association tends at present to center its concern on the correction or prevention of deviations of mental health. Its interest in the third goal, the elevation of mental health, is given secondary place and is expressed chiefly by supporting others who focus on positive mental health. It was because of the neglect of the mentally ill that mental health associations were first started. Furthermore, there are no comparable organizations to which this responsibility can be passed. On the other hand, the aspects of the field which have to do with the development of positive mental health are of central interest to other organizations such as those concerned with the fields of education, recreation, etc. To them the deviations, especially the severe deviations, are peripheral. A mental health association in planning its program may discover that a child-study organization is covering parent education quite adequately. The mental health association is then in a position to lend that group backing rather than to compete with it and fragment the community effort. All the social institutions described in the succeeding chapters are in varying ways an appropriate concern of a general mental health association.

Criterion 2—Seriousness. It is useful to know whether a certain aspect of the field is of greater or lesser import to people whose mental health is involved. Figuratively speaking, does it deal with a pimple or a carbuncle? On the positive side, is it concerned with undeveloped skill of little value or with enduring artistic, technical, intellectual, or social talent? Would the program promise to alleviate a serious disorder to only a slight degree, or provide full cure for a less serious one? Sometimes seriousness can be measured in such terms as school grades or by morbidity or mortality statistics. But more often it is necessary to depend on expert judgment.

The seriousness of a disorder may be reflected in part by the duration of hospitalization at death, age on admission, working years lost, rate of recovery, and readmissions. In the table (page 38) in Chapter 3, these facts are given for the categories of mental illness which constitute more than 1% of all first admissions to mental hospitals. From this it will be seen that the following rate high in seriousness: general paresis; alcoholic psychoses; psychoses of old age, senile and arteriosclerotic; involutional psychoses; organic psychoses; manic-depressive psychoses; and schizophrenia. This does not, of course, include serious problems found in other institutions.

Criterion 3—Frequency. Some problems in the mental health field are very serious but relatively uncommon. Paranoia, for example, is a most malignant mental illness, but at the same time comparatively rare. Consequently on a relative basis it would not rank as high in priority as schizophrenia. A project designed to treat cases of paranoia, no matter how successful, would affect a much smaller number of people. In the whole of New York State in 1951 there were two first admissions for paranoia as compared with 4,485 for schizophrenia.

It must be remembered that the rate of admissions to mental hospitals is not a true figure of incidence, for the admission figure is influenced by the seriousness of the problem and the greatly varying provision of facilities from state to state. For example, it is estimated that less than one-tenth of the mentally deficient are placed in institutions.

We have no accurate count of the whole extent of mental illness. The best statistics have come from studies made in Baltimore and in Williamson County, Tenn., and from New York State, where the provision of hospital beds is the most generous. These statistics, however, agree surprisingly. The Baltimore study [2] discovered 365 cases of psychoses in a population of 57,002. This is 6.4 per thousand of the population, or 1,024,000 if extended to the country as a whole. The Tennessee study [3] found 156 cases in a population of 25,000, a prevalence of 6.2 per thousand, or 992,000 for the whole country. The hospitalization figures from New York State should be low compared with Baltimore and Tennessee, since they do not include future or former hospital patients who are psychotic and living in the community, nor do they account for those in veterans and temporary-care hospitals. New York's statistics [4] show 82,549 cases of psychosis on the hospital books for 1950 for a population of 14,830,192. This indicates a prevalence of 5.7 per thousand, or 919,000 for the whole country. It may be conservatively estimated that as of 1950 there were some one million psychotic persons in the country. Of these about 550,000 were patients of mental hospitals. About 100,000 were mainly in Federal, local, and private hospitals. Some 350,000 were at large in the community. Many of these last have in fact been hospitalized and discharged as good social risks, even if not recovered. They have received whatever treatment the hospital has to offer. These figures refer almost exclusively to the psychoses, since very few cases of neurosis enter our mental hospitals, although they are undoubtedly the largest psychiatric category.

The difficulty of counting cases looms large when one moves outside the medical field. Schools have their statistics on age-grade discrepancy, but some communities adhere strictly to Regents' criteria, whereas others have a policy of annual promotion regardless of achievement. Therefore these figures are hard to interpret. In the field of delinquency one community might record all cases, whereas another might handle a great many informally and pride itself on a low incidence.

These limitations of statistics and their bearing on frequency do not invalidate the effort to assess frequency as an element in planning. Certainly if one is not overly exacting there are valuable data from which good judgments can be drawn. One needs chiefly to be careful that he does not waste valuable time and effort to reach useless refinements. At the same time a recognition of our present limitations can encourage research investigators to improve our measuring devices.

Criterion 4—Social Significance. Three hundred and fifty years ago John Donne pointed out that anything that happens to a person happens also to everyone else in the society in which he lives, for society is made up of persons, each a part of a whole. But the impact upon society as a whole is not the same for all people. Some play a larger role than others, and some play a negative role, while others are positive contributors. Since the mental health of a person affects his human relationship, anything that influences mental health has social implications. The effect may be heightened if the person is in an influential position. The impact may be upon family and friends or upon production in industry. Financial costs must also be taken into account in measuring social influence of mental conditions.

Case studies show how widespread and persistent the social influence of mental health and ill-health can be. A man's neurosis can seriously disturb his family while he is still successful in business. In the next generation the effects of this family disorganization may crop up as a neurosis, sex deviation, divorce, addiction to alcohol or drugs, or perhaps ulcer or high blood pressure. On the other hand, care in the selection of mentally healthy schoolteachers may foster the emotional growth of children or even help balance an unwholesome home. Similarly mental health in the religious counselor, the employer, the social worker, or other professional person occupied with solving human problems is a boon not only to the professional himself but to all those whom he serves.

In terms of tax costs the following per-case maintenance costs bear upon criterion 4. State hospitals in the United States cost over $500,000,000, not counting the capital costs and the carrying charges. The value of hospital-construction cost in 1954 was as high as $12,000 per bed. Mental deficiency and epilepsy cost over $120,000,000. Institutions for juvenile delinquency $50,000,000; prisons, $170,000,000. Out-patient clinics are estimated to cost the country some $2,500,000 per year; veterans' hospitals, $180,000,000. The education of a mentally deficient child in public schools costs about 60% more per year than that of a normal child. Every time a child repeats a grade in school, it costs the public up to $250. New York City spends about $1,500,000 additional per year to educate its mentally retarded. More difficult of calculation are the costs of social service, recreation, group work, juvenile court work, etc.

The impact upon society of good mental health may be calculated in terms of increased productivity and earnings and increased capacity to pay taxes or make voluntary financial contributions.

Criterion 5—Extent of Knowledge. Some things that are done to further mental health are well justified by scientific knowledge. Others are still hypothetical. Some are blind guesses, unsupported by either hypothesis or scientific fact. All these may on occasion be justified if they use the best knowledge available. But obviously, scientifically well-founded activities can with greater justification be included in a program than can those based on a mere guess. Sometimes our knowledge is so limited that the only highly justified step ahead is research. On the other hand, research may become a retreat. Sometimes when the knowledge that already exists is not being used, the demand for more knowledge becomes a smoke screen.

Sometimes knowledge may exist in the scientific literature. But to be useful it must also be a part of the equipment of practicing personnel. For example, the medical diagnostic categories of mental deficiency are to be found in the scientific literature, but it is the rare practitioner who knows them. It is therefore helpful in applying criterion 5 to determine the availability of personnel needed for the field or the project. It may be that no steps can be taken in activating the project until personnel are trained.

It is well to be clear about the scientific status of any project. Upon what facts, hypothesis, or assumption is it based? Is it merely a hunch? Is it ready for generalization, or are trials the next step? Is more research needed to justify even a trial? It may be well to remember that the launching of an ill-founded project may be more than a waste of the resources devoted to it. Premature conclusions and unfounded assumptions may force the expenditure of valuable research effort to reveal the fallacy. Untested assumptions that are set forth too assuredly retard progress in that they obscure the need for further research.

Of course, when more abundant knowledge exists than is being used, criterion 6 should be given special attention. In this case it is apt to be found that public support, either financial or in terms of sanctions, is weak.

Criterion 6—Attitude of the Public. Even if the application of criteria 1 to 5 establishes a high priority for an undertaking, some highly needed action may have to be postponed. If a project is dependent upon public support, the public must be sold on it enough to provide its sanction. Where such participation is lacking, no matter what other justifications exist, the only step possible may be public education specifically pointed toward enlisting such support. For example, mental deficiency would stand in high priority according to the first five criteria. Yet, as will be seen in Chapter 9, with all this justification, social action in this field is greatly retarded because the public, including the professional public, do not believe there is much to be gained by expenditures of money and interest in behalf of the mentally deficient. The immediate task therefore may be to develop a more understanding and responsive public.

On the other hand, the application of criterion 6 may lead to the conclusion that the public has already responded well to a need. New York, Massachusetts, and New Hampshire show a relatively high level of citizen responsibility for the mentally ill. They provided, as of 1950, one bed for 179, 198, and 212 of the population respectively. The overcrowding of their state hospitals was at the same time low, being 20.0, 20.7, and 15.7 respectively. In such states a campaign for more beds would have been of lower priority, therefore, than in a state such as New Jersey whose provision was only one bed per 262 of the population, with 32.6% overcrowding.

The application of this criterion may, on the one hand, show that there is so much well-accepted and well-supported action already under way that attention may profitably be turned toward more neglected problems. Taking an example again from the field of mental deficiency, a serious problem by the dictates of the first five criteria is cerebral palsy; less serious is mongolism. Still the high degree of support already afforded the cases of cerebral palsy for research, training of personnel, training of the patients, etc., might fully justify giving attention to mongolism, a relatively neglected problem.

Sometimes it is not the attitude of the general public but that of the professions that obstructs progress. A proposal to establish a special mental health faculty in the schools or to use existing clinic services may be blocked by professional opposition. The project may then need to be postponed until better professional support is enlisted.

THE ALLIES

The planning of program also calls for the identification of agencies that are appropriately concerned with mental health and that are especially suited to carry certain responsibilities. One must determine also whether these agencies are ready to participate. It is sometimes necessary as a first step to activate them or even to create an agency where none exists. For example, a group that is interested in starting a child-guidance clinic has on occasion decided that a general child-welfare agency should precede the opening of a clinic and that a committee of citizens should be formed for this purpose. In brief, an early step in program planning may be to strengthen the potential allied agencies.

The agencies in a mental health program are of two general types. First, there are allied agencies that work side by side within the same territory with some common interests but with *different objectives* and roles. Some of these are voluntary citizens' organizations such as mental health associations. Then there are the professional associations—associations of psychiatrists, psychologists, nurses, social workers, etc. There are agencies of government concerned with schools, public health, welfare, hospitals, etc. There are also educational institutions such as colleges which are concerned less with specific social action than with the equipment of the student to function in social action as needed.

Secondly, there are partner agencies which have the same objective but which differ in *geographical scope*—some local, some statewide, some national or international. These, of course, may be professional, voluntary, or governmental. Examples are shown in the following table.

ALLIES

Professional partners	Governmental partners	Voluntary partners
International Medical Association	World Health Organization	World Federation for Mental Health
American Medical Association	United States Public Health Service	National Association for Mental Health
Medical Society of the State of Pennsylvania	Pennsylvania Department of Public Health	Pennsylvania Mental Health, Inc.
Philadelphia County Medical Society	Department of Public Health, City of Philadelphia	Southeastern Pennsylvania Association for Mental Health

In the planning of program the differential functions of all these may be taken into account as potential allies and partners.

STEPS IN PROGRAM PLANNING

Starting with the criteria it is now possible to suggest a sound procedure of program planning. Such a procedure will take into account not only the facts that make the program sound but the division of labor and interprofessional and interagency collaboration which will make it comprehensive and effective. Twelve specific steps are suggested for any element of program:

Step 1. Evaluation from the standpoint of criterion 1—*appropriateness.*

Step 2. Evaluation from the standpoint of criterion 2—*seriousness.*

Step 3. Evaluation from the standpoint of criterion 3—*frequency.*

Step 4. Evaluation from the standpoint of criterion 4—*social significance.*

Step 5. Evaluation from the standpoint of criterion 5—*extent of knowledge.*

Step 6. Evaluation from the standpoint of criterion 6—*attitude of the public.*

Step 7. At this point it is often of value to group or divide proposals under consideration and reevaluate them to test their priority when *subdivided* or *combined,* e.g., the priority of vocational rehabilitation of mental hospital patients may be raised when combined with that of outpatients, or with employment services, or both.

Step 8. From the first seven steps applied to several potential areas or potential programs a *priority* is established.

Step 9. It can be anticipated that certain agencies may need to *join hands* as allies to achieve best results. These agencies should be encouraged to confer and outline a single comprehensive program of action. In general this collaboration would include professional, voluntary, and governmental agencies within the mental health field and agencies related but not designated as mental health agencies, such as a state employment service.

Step 10. The conference should assign to each agency the part of the task that is appropriate to it and within its resources. Conferences between the participating agencies should continue throughout the execution of the program. This may result in later changes in the initial plan and in the *division of labor.*

Step 11. Depending on the project, each participating field may need to outline a different task for its national, state, and local divisions or partners.

Step 12. Within each agency there is often a differentiation of staff—some are occupied with the scientific aspects, e.g., research; some with educational operations; others with organizing people for action. When the *division of labor* of each of these staff divisions is agreed on, and detailed, the program is ready to become an activity.

Where an aspect of a program can follow a well-beaten path with experience as a guide, it is possible to plan it in full from start to finish. The establishment of a child-guidance clinic would be such a case. Where, on the other hand, the way is not so clear, it is sometimes better to *plan the program in stages,* each successive stage depending on experience with preceding ones. Usually both possibilities exist side by side. It is nearly always possible to identify the elements in an undertaking which call for more study, survey, research, and experiment and to plan for these even while moving ahead toward an intermediate goal.

Example. A summary example is given below of a program for the development of psychiatric services in general hospitals. This program was arrived at by the above steps. It embodies both study and experiment to cope with unknowns and promotion to bring well-established experience into practice.

Step 1. Appropriateness. Psychiatric service in general hospitals is obviously within the mental health field.

Step 2. Seriousness. General hospital patients with serious physical illness such as pneumonia complicated by delirium, and with childbirth complicated by mental disorder, are endangered when, as often happens, they are transferred to a mental hospital. Also psychiatric treatment is thereby delayed. In addition, psychiatric patients who are not recognized as such are admitted to a general hospital but are not treated as such. Obvious psychiatric patients who can very well be treated in a general hospital, or patients for whom observation is needed, are often denied admission and instead are kept in jails.

Step 3. Frequency. Admissions to general hospitals total 18,000,000 cases per year. It is estimated conservatively that one-fourth of the patients admitted to a general hospital are primarily psychiatric. About 25% more suffer from physical disorder complicated by mental disorder and need psychiatric consultation and treatment.

Step 4. Social significance. There is less disruption of the family if the patient can be kept closer to home than is usually possible when a state hospital is used. In fact, prompt and brief treatment or observation in a general hospital often makes a longer stay in a public mental hospital unnecessary, with consequent saving in taxes. A psychiatric program in a general hospital also helps to broaden the training of physicians (interns) and nurses and the services rendered to all patients.

Step 5. Extent of knowledge. Architectural experiment has shown that a unit for psychiatric patients can be constructed in a general hospital in such a way that even noisy ones do not disturb medical and surgical patients. It has also been shown that such a unit can be financially self-supporting. It has been demonstrated that treatment for almost all categories of mental illness can be carried out within a general hospital.

Step 6. Attitude of the public. There is resistance to the admission of the mentally ill to general hospitals. It has not been determined how much this resistance comes from the trustees, the medical staff, the patient, or the general public. Nor have there been scientific studies to show why they resist. Studies are needed to clarify these points so that plans can be made to overcome this resistance. Personnel are available for this purpose.

Step 7. Rearrangement. It has been found that prepayment hospital plans for psychiatric cases are dependent in part upon the ability of a contracting hospital to provide psychiatric service and its policy on admitting such cases. It is, therefore, well to combine into one program the effort to broaden insurance coverage to include the mentally ill and to develop psychiatric services in general hospitals.

Step 8. Priority. A comparison of the need for psychiatric services in general hospitals with other mental health needs leads to the conclusion that psychiatric service in general hospitals is high in priority. The promotion of such service is appropriately included early in a program and budget of a mental health association.

Step 9. Joint planning. Psychiatric service in general hospitals is of interest not only to mental health associations but to county medical societies, hospital associations, hospital insurance plans, psychiatric associations, public health authorities, and others. A planning conference of representatives of these interests is needed to provide an over-all plan of action.

Step 10. Interagency division of labor. The county medical society would plan its scientific programs so as to bring before all physicians the role of mental and emotional disorders in their cases, the evidences of these disorders, how they may deal with them, and the function of the specialist. The hospitals would inspect their physical plant to determine its adaptability to various kinds of psychiatric services, study the attitudes of its staff, trustees, and the public, and clarify its admission policies with respect to psychiatric disorders. Prepayment hospitalization authorities would clarify the extent to which psychiatric cases are covered and under what conditions they might, if necessary, liberalize their coverage of psychiatric cases. The psychiatric association would gather information on the various patterns of psychiatric service and standards of personnel. The public health authority would determine how this service might be linked with their preventive and educational work.

Step 11. Mental health association plans. The mental health associations as their share in the plan of action would work through the national, state, and local offices. The national office would bring together general information on the subject. It would prepare a guide for those interested in developing psychiatric services in general hospitals. It would assist state associations in planning this aspect of their programs. It would give special assistance to two hospitals, one in a large community and one in a small community, to serve as demonstration centers for research and centers for the training of personnel. It would provide an expert consultant for those who are planning the development of such a service, and it would study especially difficult situations in order to reveal obstructive factors and experiment with methods of eliminating these factors.

The state mental health association would encourage local associations to include the development of psychiatric service in general hospitals in their programs. It would determine the availability of state and Federal hospital construction funds for this purpose. It would investigate regional plans for hospital service and encourage provision for psychiatric patients in such plans. It would work with state mental hospital authorities to determine whether the staff of these hospitals can be assigned as consultants to general hospitals and whether general hospitals may be reimbursed for cases which would otherwise be admitted to the state hospital. The state association would keep in close touch with all interested state organizations and agencies in order to bring about joint planning and action.

The local mental health association would survey the hospitals within its territory to determine the existing status of psychiatric service in general hospitals, their readiness for such service, points of obstruction, and reasons therefor. It would work with other interested organizations and agencies in laying plans for a local program. It would use consultants having technical knowledge such as architects. It would carry on public education. It would enlist volunteers, arrange for liaison with the state hospitals, and study the present facilities for detention of patients pending their transfer to the state hospital. It would encourage provision for covering psychiatric illnesses in the prepayment plans for hospitalization.

Step 12. Intra-agency division of labor. Within any mental health association the medical director would bring together such scientific reports as have a bearing on this subject. He would conduct studies designed to reveal the sources of resistance and would work with other staff members in planning methods of eliminating this resistance. He would conduct studies on the use of volunteers and their effect upon the improvement of patients. He would arrange for a panel of technical consultants. He would develop proposals for the correlation of the clinical work of the state mental hospital and the general hospital.

The director of education would prepare a guide for those who are promoting psychiatric services in general hospitals. He would develop exhibits and would plan for newspaper reports, conferences of interested persons, and presentations to lay and professional bodies. He would prepare plans for use through other media of general communication, with special reference to appropriate audiences and appropriate messages for this particular goal.

The director of citizen mobilization would aid in the development of state and local committees on this subject. He would provide suggestions for legislative procedures, for participation in prepayment hospitalization plans, and for collaboration between the interested organizations and agencies. He would make the local arrangements for experiments and demonstrations. He would encourage the use of consultants. He would help plan studies of current methods of detention of mentally ill persons pending hospitalization. He would bring together information about local problems and experience with regional planning. He would provide counsel in the enlistment and use of volunteers.

PITFALLS AND GUIDES TO PLANNING

If a program is to be practical it must, of course, be founded upon fact as far as fact is obtainable. But it also must be the result of clear thinking, for a program cannot be built out of facts alone. It is at this point that planning often goes awry. If the planning is being done by one person, the pitfalls are reduced to his own logical processes, for his premises are apt to remain fairly constant. Group planning often becomes confused because different members of the group try to deal with different issues at the same time. But the ease and simplicity of planning by one person is the result in part of the limitation of his grasp. Group planning, even though more cumbersome, is nevertheless more promising, for it brings to bear a richer experience and varied points of view and skills. It is, therefore, helpful to clarify at the start of any deliberation just what is to be discussed. If a shift is needed in the course of discussion, this can then be made intentionally, avoiding confusion.

The following elements of planning are often mixed unwittingly. If each of these elements is given its place in an orderly sequence beginning with the most general, i.e., the aims and objectives, and moving step by step toward the most specific, it will conserve time, prevent emotional cross currents, and result in more satisfactory conclusion. It should be kept clear which of the following is under consideration at any time:

1. Aims and objectives—what we hope to achieve
2. Role—our part of the job
3. Potential program—things we might appropriately do
4. Program—what we shall do
5. Activities—what we are doing
6. Report—what we did

As a kind of backdrop in determining role and potential program, a set of guiding principles may be agreed on. For example, a test of the appropriateness of any part of the potential program of a citizens' mental health association is whether that activity is appropriate for citizens. The failure to have established such principles is often responsible for confusion in program.

With these distinctions clearly defined, it is possible in any planning session to say, e.g., "We are at this point considering potential program. We have established our aims and objectives and our scope. We are not ready as yet to settle on our program. That will come later." This may seem very elementary, but it is a reality of human imperfection that common sense needs some such guide.

Another pitfall comes about because of the perennial worry about finances. This preoccupation is apt to divert the planning away from the things of high priority toward the things that will attract money. As has been previously pointed out, this is not entirely a meretricious fault, since the responsiveness of the public must be taken into account according to criterion 6. But sound planning will accept such diversion as temporary only and take steps to ensure its transiency.

A hazard in planning also lies in the failure to distinguish between aims and instrumentalities. In a mental health association public education, research, and the training of personnel are instrumentalities for the achievement of a certain objective. They are not, except perhaps in a university, goals in themselves—certainly not in a mental health association. Yet they are in high popular repute and as such apt to be attractive in themselves to program planners. They have their place, but as a means of reaching a well-defined goal.

NOTES

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PART TWO

The Restoration of Mental Health

3 THE MENTALLY DISORDERED

Judged by the six criteria, the restoration of mental health would appear to be the most immediate of the three goals. It deals with a most serious form of human misery. Mental handicaps affect some nine million persons seriously enough to call for special help. In addition they reduce the effectiveness of uncounted others. They play havoc with families, friends, communities, and industry. They encumber society with an immense financial burden, a burden that is unequaled by that of any other human disorder. At the same time there is more scientific knowledge and technique for dealing with mental illness than is now being used. The public has shown a willingness to meet the needs of the mentally ill in varying degrees from state to state, but always short of the need. It usually provides custody, and it protects itself from the dangers of the mentally ill. But only exceptionally does the public show a willingness to provide all that science has to offer, to encourage or to support further research, and to ensure a steady supply of well-prepared personnel. Unfortunately it condones a serious amount of neglect.

But the mentally ill are not the only losers. The "quality of mercy" also "blesseth him that gives" it. It is doubtful if a people can advance its civilization soundly if it considers sick persons expendable while it tries to salve its conscience by occupying itself with an uncertain prevention and with positive mental health. As a first step toward social progress one must find the answer to these questions: Who are these mentally ill? Where are they? Through changes in what social institutions can they be helped?

WHO ARE THE MENTALLY ILL?

The characteristics of the mentally ill vary greatly. Some are so confused as to where they are, or who they are, or who others are that there can be no doubt about the seriousness of their abnormality. Others are excessively elated or depressed or unresponsive. Some use such strange processes of thinking that they are unintelligible. All these people are suffering severe mental illness which the law calls insanity.

Then there are others whose mental illness is not so extreme but who still are so handicapped by doubts, fears, compulsions, and worries that they become ineffective. These people are often quite aware that they are ill, but they may not realize that they suffer from psychoneurosis. They are not usually found in our mental hospitals but are often patients in general hospitals because their tensions induce or aggravate disorders of their internal organs. They are found among the clientele of private physicians and in clinics. They commonly show up as problems in their occupations.

Another group is so unresponsive to the demands of society that they are in constant trouble with the law, and, of course, many of these are in correctional institutions. Many of them are labeled "psychopathic personality." This is not too bad a name as long as it is used as a class name and not a medical diagnosis, but inherently it means little, for every mentally ill person is psychopathic.

Some mental disorders, the epilepsies, consist of episodes of loss of consciousness with convulsions.

There are others of the mentally handicapped who are severely limited in their intellectual capacity. They are deficient in their ability to think abstractly and they get into trouble when the situations of life in which they find themselves are too complex for them. They tend to be slow in school. They are able to do uncomplicated jobs but are usually on the borderline economically. But these people are not strange in their behavior as are those who have a psychosis. They are the mentally deficient.

Psychosis, neurosis, psychopathic personality, epilepsy, and mental deficiency are all classes of seriously disordered human behavior. They are not diagnostic terms. Nor do these terms mean that the disorder is always clear-cut. Neither are these disorders always so great as to offer a clear distinction from normality. In real life people may suffer from mental disorders in any degree, and they often have one in combination with another, e.g., mental deficiency is often combined with epilepsy, or schizophrenia. Some cases are hard to classify because they are on the borderline.

CLASSIFICATION

Society as a rule looks upon sick persons with compassion and gives them the care that they need. But in contrast they often see the mentally ill first of all as a public danger. Only later, as cases of social disorder are sorted by medical practitioners, courts, hospitals, clinics, welfare agencies, and correctional institutions, does the mental illness become the major concern. Then the troublemaker, the arsonist, the deserter from his family, the absentee from industry, or the murderer is seen to be basically mentally ill. But the element of compassion is seldom as deep as with other illness.

Buell[1] and his associates, through community studies, have shown how a few families in a community absorb a high proportion of welfare and health services and how the mental and social disorders tend to occur in combination far beyond the expectation of chance. Social failure may result from physical and cultural as well as mental disorder. In fact social problems seldom appear in pure form. It is, therefore, often not possible to say simply that this social problem is due to crippling, that one to visual defect, or the other to limited intelligence.

The classification of any specific case not infrequently reflects the bias of the specialist into whose hands the case happens to fall. Classification is at best imperfect. It is essential, therefore, that anyone who is dealing with mental disorders be practical enough to use a classification, even though it is imperfect, and scientific enough to be aware of its limitations.

Where a disorder is due to a combination of causes, the classification is often based upon one cause that stands out most prominently. This does not mean that minor or less evident causes can be ignored, for without their contribution to the total load of causes there might be no overt problem. For example, mental deficiency, in spite of its classification, is the result of much more than poverty of intelligence. It involves emotional disabilities as well, and neglect of the less obvious (emotional) factors often results in failure to help the mentally deficient. At the same time it should be recognized that one factor may at times be so influential that, even under the most favorable circumstances otherwise, the victim cannot reach the level of behavior which society expects of its self-sufficient members. Thus, for example, psychological studies of World War I indicate that an adult whose intelligence is no better than that of a normal 8-year-old will not be able to carry his own weight socially even under the most favorable conditions of health and cultural benevolence. Such a case could be classified as exclusively one of mental deficiency. But such pure cases are rare. Since the mental age of 8 is far below the borderline of mental deficiency, the classification of mental deficiency above this 8-year level is based upon only the predominance of a defect of intelligence as a cause. This cause is complemented by other defects, without which there would be no social failure. Likewise when the intellectual resources of the person who is failing socially are just above the borderline of intellectual normality, some other factor such as emotional instability predominates. The classification of such a case would then be thrown in the direction of a neurosis. For purposes of treatment, however, all factors must be recognized. This illustration is offered merely to emphasize that these classifications are somewhat artificial and that the disorders are much more complex than the classification ordinarily implies.

CLASSIFICATION AND DIAGNOSIS

It has already been pointed out that a classification is not considered a diagnosis. The distinction is important, for a classification does not account for all the factors, whereas diagnosis should. If the classification of a social failure is accepted as the diagnosis, we have the common and very unfortunate result that the treatment is limited to the predominant factors rather than to all the disabilities that bear the person down. A full diagnosis specifying all the important factors leads to a multiplicity of alternate or combined opportunities for treatment and to better prospects of success. The failure to make a full diagnosis correspondingly reduces the opportunities for attack. An adequate diagnosis, of course, goes even further than a determination that certain factors are involved. It specifies the nature of the disorders in terms of scientific nosology and in terms of an individual quantitative and qualitative evaluation. For example, cerebral palsy is only a partial medical diagnosis. There is such an immense variation in the form and degree of disability of cases of cerebral palsy that this brief diagnosis alone is insufficient as a basis for treatment. Cerebral palsy cases vary as to cause, location, and size of the injury. They range from extremely low-grade mental deficiency up to what is relatively unimpaired intelligence. They also range downward from the severest lack of muscular control to motor defects that are barely detectable.

The available techniques for making a quantitative evaluation of a disorder vary. In some areas there are good measures. In others the decision is dependent primarily upon clinical judgment and is often crudely expressed in such terms as severe, moderate, and mild. As a result of this limitation of techniques, in cases of cerebral palsy with mental deficiency and with slight motor impairment, an improper diagnosis is sometimes made.

Nosology and Statistics. It is not generally appreciated how extensive the classification of mental disorder is. The *Diagnostic and Statistical Manual of Mental Disorders*[2] issued by the American Psychiatric Association presents this list in fairly complete form. Even in this, however, the category of mental deficiency is not broken down into the 70 or so diagnoses in which severe impairment of intelligence is found.

For clinical and preventive purposes, and especially for research purposes, a detailed classification of disease entities is most essential. But for statistical purposes a more useful classification is that employed in the statistical reports of hospitalization issued by the National Institute of Mental Health.[3] The more common group of disorders listed in this statistical classification are given below, along with data that will help in applying some of the criteria described in Chapter 2. However, psychoneurosis, epilepsy, drug addiction, and primary behavior disorders occur more frequently than indicated in these hospital statistics, since patients with these disorders are not usually hospitalized. The frequency of hospitalization for a disorder is indicated by its percentage among first admissions to mental hospitals and its frequency in the census of the hospital. Its seriousness in the life of the person is shown by the median age, working years lost, and length of hospitalization. Where national data are not available, statistics from larger states, New York and California, are quoted.

Since discharge from the hospital may follow varying degrees of improvement classified as recovered, improved, or unimproved, and admissions may be either first admissions or readmissions, there is no good indicator of recoverability. In fact the statistics at present are not an accounting of the changes in individual cases which have been followed for a period of time. Consequently the reports cannot include percentages of recovery, but merely ratios of recovery to admissions. There is need for more statistics on cohorts, i.e., groups of patients followed through from the beginning of the illness to its end, with each change of status recorded.

PARTIAL STATE HOSPITAL STATISTICS

Classification	Percentage of first admissions to state hospitals, 1%, U.S. where over	Percentage of census		Readmissions to 100 first admissions, 1951, N.Y.	Median age on admission, U.S.	Working years lost	Death rate, %, N.Y., 1950	Hospital duration at death, years, N.Y., 1950
		Calif. 1952,	1951, N.Y.					
Psychoses:								
General paresis	3.5	4.8	3.8	22.2	47.2	8.8	6.2	7.0
Alcoholic	4.9	3.6	3.8	24.6	45.2	6.7	4.4	7.9
With cerebral arteriosclerosis	14.8	8.3	8.4	8.3	70.0	0.7	24.5	1.9
Senile	13.6	8.3	5.2	3.9	70.0	0.1	29.2	1.5
Involutional psychoses	4.4	4.0	4.9	25.3	53.1	4.6	3.8	6.2
With organic changes of the nervous system	1.1	0.8	0.6	19.5	52.0	9.9	11.5	
Manic-depressive	5.5	4.7	4.2	68.2	41.3	7.4	3.1	12.0
Schizophrenia (dementia precox)	21.5	51.4	57.7	38.0	32.6	16.7	1.2	20.3
With mental deficiency	2.3	3.1	....	32.4	31.7			
Mental deficiency	1.3	0.4	....	....	25.1			
Alcoholism	6.8	....	....	....	42.6			
Psychopathic personality	12.0	....	....	....	27.8			

Not all patients in a mental hospital are mentally ill. Many patients are admitted because of severe social problems but have not had the advantage of expert diagnostic service prior to admission. Most of those admitted will in fact be found to be mentally ill, but some will be discharged promptly as "without psychosis." Likewise not all the mentally ill are in mental hospitals. Many obviously mentally ill persons will be found in the community; they are not hospitalized because they are considered good social risks. They may be receiving treatment in outpatient psychiatric services.

SELECTED DIAGNOSTIC GROUPS

There would be little value in repeating at this point a description of all the mental illnesses that are found in the statistical reports of the National Institute of Mental Health. Any textbook of psychiatry can be referred to for such detail. However, four forms of mental illness of high priority—alcoholic psychoses, the psychoses of old age, schizophrenia, and psychoneuroses—are selected for special attention because they illustrate certain principles that underlie the chapters which follow.

Alcoholism. Alcoholic psychoses are the result of long-standing overindulgence in alcohol. Jellinek [4] estimated in 1947 that there were 945,000 persons in the United States who because of alcoholic excess had developed bodily or mental disorders. These illnesses vary greatly. There are several forms of alcoholic psychoses. Some are seriously chronic and intractable. Some of the symptoms of alcoholism are not directly due to the alcohol, but rather are due secondarily to other results of alcoholism such as dietary deficiency attendant upon disturbed eating habits during prolonged sprees. Most patients recover when the consumption of alcohol is eliminated and a normal regime established, except that they are usually still unable to limit their indulgence to moderate amounts. In arrested cases of alcoholism, consequently, relapse is most common.

Overindulgence in alcohol is itself a symptom of serious emotional disturbance, perhaps combined with some as yet unknown physical peculiarity. While theoretically limitation of the intake of alcohol is an absolute preventive of alcoholic psychosis, this control is most difficult to effect, for it calls for drastic emotional readjustments by the victim. These readjustments can be achieved more easily when the stresses of life are reduced, but the most serious stresses are found within the emotional make-up of the victim himself. Sometimes he can be helped by psychiatric treatment, sometimes by combined social and religious support such as is offered by Alcoholics Anonymous and the Salvation Army. While acute and chronic alcoholism are common forms of illness, the training of physicians to deal with the psychological elements in alcoholism is seriously neglected.

An expert committee [5] of the World Health Organization has provided an excellent perspective on alcoholism as a problem for social action. This committee points to the failure of public health authorities and medical authorities to assume a more aggressive attitude toward its prevention and treatment. They attribute the professional lag to the recency of a scientific approach to the problem and the failure of the public to distinguish between its moral and scientific aspects. The committee also points to the variation from country to country in drinking customs. This cultural influence is a factor to be taken into account, especially in the United States, where varying national customs interlock. But better statistics bearing on these and other factors are needed to open the way to research and improved treatment. The committee is sanguine about the treatment of alcoholic patients by outpatient services, especially as set up in general hospitals, but is opposed to the attachment of such services to hospitals for severe mental illness. It believes that these services cannot function effectively in isolation but must work closely and exchange knowledge with the other community agencies which are concerned with the problem. The committee is hopeful about the use of drugs in the early treatment of alcoholism.

The National Research Council through its Committee on Problems of Alcohol allocates some $42,000 per year to research. These researches are carried out in a number of medical centers throughout the United States. Also some states have established research funds for this same purpose. A study by Joseph Hirsh [6] in 1955 showed that 19 states carry on research and that in 1954 they spent for this purpose something in excess of $211,000.

Alcoholism is of special interest as an example of a condition that begins with an emotional disorder, which brings about an organic (toxic) disorder, which in turn may result in irreversible brain changes. The problem may be further complicated by certain physiological (metabolic) peculiarities. Alcoholism is also of interest in showing how cultural factors tend to contribute to the problem and at the same time to hamper the scientific attack upon it.

Mental Illness of Aging. Cerebral arteriosclerosis and senile dementia may well be grouped together, since autopsy studies cast doubt upon the clinical distinctions between the two disorders. As a rule these patients have very limited prospect of recovery. In fact, they die on the average within fifteen months after admission to a mental hospital. In these disorders of old age there is a tendency for memory to decline. Typically it fades first for recent events, even while occurrences of early life may still be clearly recalled. In its early stages the mental impairment is apt to be quite irregular. A patient may be confused, disoriented, combative, and delusional one day, and a few days later be almost like his old self. It is uncertain whether these fluctuations are due to nutritional, metabolic, or other biochemical or psychological causes. It has been found that the mental confusion in the senile patient is often brought about by emotional disturbances. Research into these disorders is badly neglected, partly because these patients are considered doomed anyway, and the return on the research investment will be of shorter duration than in some other disorders. But the loss to society may be even greater than the loss of those patients, for by neglecting research into senile and arteriosclerotic psychosis we may be missing important leads that bear upon the physiological and psychological processes of earlier years.

It is often stated that these patients are responsible for the serious overcrowding of our mental hospitals, since they constitute up to one-third of the admissions. However, they die so soon after admission that they seldom account for more than 15% of the patients found in such hospitals. It is also claimed that most of them do not belong in mental hospitals and could be served more economically by some other placement. Case-by-case studies, however, have shown that from 50 to nearly 100% are appropriately hospitalized. At most, therefore, the elimination of all inappropriate cases would reduce the hospital population by only 8%. This falls far short of solving the problem, since the average national overcrowding is 18%. It is questionable also whether any financial saving could be made by placing these patients elsewhere when the allowance for the maintenance of patients in state hospitals is already so low. Undoubtedly better care is possible for the nonpsychotic senile patients, but it will have to be specifically designed for them. The almshouse is not the answer. The 1950 report of the Council of State Governments [7] urged that old-age insurance, public assistance, and community facilities be increased to deal with the increasing numbers of senile people.

Senile mental disorders are of special significance because they highlight the neglect of promising leads to research. Persons with these disorders are victims of a culture which puts a low value on a person in his declining years, with resultant neglect of both research and treatment. The confusion which follows emotionally upsetting situations emphasizes the fact that, even where the organic factor predominates, the symptoms may be improved by careful control of the psychological atmosphere.

Schizophrenia. The most prevalent of the mental illnesses in our state hospitals is schizophrenia (dementia precox). In fact, the popular conception of mental illness corresponds to schizophrenia. This illness includes most of those who believe they are great personages or deities, who believe they are the subjects of designed persecution, who converse with imaginary persons, and who in general behave in a bizarre fashion. The onset is insidious, although it may erupt unexpectedly. In fact most cases show evidence of the illness far in advance of its diagnosis. Whether schizophrenia is essentially one illness or several basically different disorders with similar psychological characteristics is also uncertain. The fact that 10% of the patients admitted to state mental hospitals for the first time with a diagnosis of schizophrenia are over 50 years of age suggests delayed hospitalization or doubtful diagnosis. About 20% of schizophrenic patients recover, and many others improve to the point of being able to return home. Others may remain in the hospital for decades. Occasionally schizophrenia is found in early childhood, in which case the disorder tends to be much more malignant and unresponsive to treatment.

Waking life for the schizophrenic patient takes on some of the irregularity, unpredictability, violence, and distortion that well people experience only in dreams. It is this inability to distinguish between reality and the concepts and pictures conjured up by the imagination that characterizes the psychological side of the disorder. Some, however, gradually lose interest in the world about them and regress to a state of complete dependence that is more like babyhood. The condition in general is that of a personality which has fallen apart, each fragment apparently trying to live its own life without reference to the remainder or to the world about.

Sometimes schizophrenia is more episodic than chronic. Under great stress, as in the Armed Forces, a schizophrenic breakdown may take place in a person who has theretofore been able to get along quite well. With the removal of the stress on discharge to civilian life, many experience a full remission.

Studies of twins have shown that there is a hereditary susceptibility to schizophrenia. But this susceptibility declines rapidly as the degree of relationship to a schizophrenic person declines. In any case it is not entirely determinative, for about 15% who have a clear predisposition escape the disorder. There is a growing belief that schizophrenia is basically a disturbance in the body chemistry, possibly dependent on disturbed hormone production. But this does not mean that psychological factors do not play an important part in causing the disorder. In fact the 15% of susceptible persons who do not break down may have been saved by more fortunate psychological circumstances. Two empirical physiological therapies, insulin coma and electroshock, seem to be more effective when accompanied and followed for several months by psychotherapy. Patients who have apparently recovered often suffer a relapse when the psychological pressures in life become severe. Unfortunately the shortage of personnel in most mental hospitals has made it impossible to provide these patients with the needed psychotherapy. Nowhere else in medicine is inadequate treatment so readily tolerated as in the services to the mentally ill. The plight of schizophrenic patients shows how malignant is the public belief of incurability, as a result of which it fails to provide the best treatment that science has to offer.

Specific prevention of schizophrenia must await further scientific advances. However, the institution of more wholesome conditions for the child during development is a common-sense precaution. Those who have suffered from schizophrenia and recovered or improved may also be safeguarded by protection from the conditions which seemed to precipitate the break.

For many years the only extensively coordinated research in psychiatry has been the schizophrenia research which is conducted by the Northern Jurisdiction Scottish Rite, Thirty-third Degree, through the National Association for Mental Health. It involves some seventeen research centers throughout the United States and Canada.

Schizophrenia demonstrates the inseparability of physiological and psychological functions. Dysfunction of certain glands exists, and at the same time psychological forces are potent in precipitating and aggravating the disorder. As with alcoholic and senile psychoses, what the schizophrenic patient thinks about is less characteristic than how he thinks.

Psychoneuroses. The neuroses constitute only a small percentage of the admissions to mental hospitals and on the average produce less disability than do the psychoses. But because of their frequency they probably take a larger toll of their victims and of society than any other disorder. Estimates for the United States are of the general magnitude of five million cases. The neurosis lies behind many human failures such as failures of marriage, of parenthood, of vocational achievement, of citizenship, and of respect for the law.

While the psychoneurosis may have many factors behind it, both bodily and experiential, it seems more than the other disorders to be dependent upon habits of feeling and reacting toward oneself, other people, and the world in general. These habits are established in the early years of development and influence all psychological processes thereafter. Usually the person is unaware of them. The development of habits of feeling and reacting is not in itself pathological, for in fact the very process of mental development entails the shaping and fixing of psychological habits, including those of feeling. Anxiety, hostility, fear, anger, and love come to be felt and expressed by each person in his own special way, and there are certain conditions to which he is sensitive and responds emotionally more (or less) readily than do other people, or more (or less) than he responds to other conditions. These special reactions become a part of the economy of his daily living—sometimes to his advantage, sometimes not. The habits are not in themselves the illness (neurosis), for they enter into both his successes and his failures. Since they may underlie talents as well as weaknesses, it may be better to restrict the term *psychoneurosis,* which has negative connotations, to the emotional turmoil of the individual when these feelings and habits work to his disadvantage.

The dual—positive and negative—result of these habits is shown in the person who is preoccupied with detail, the so-called compulsive personality. There are cases in which the disabling effects of this characteristic are so dominant that they afford little on the positive side and the incapacitation is complete. On the other hand, depending on the situation, this quality may ensure success and be considered a talent. From this viewpoint, then, the neurosis consists not merely of the character quality but of this quality active in a situation in which it is a hindrance.

Since the criterion of mental disorder is so often the adjustment of the individual in society, a concept of normal behavior is of practical importance. According to Ginsburg[8] "'normal' is a purely relative term." In general it means "to be able to hold a job, have a family, not get in trouble with the law, enjoy the usual opportunities for pleasure, and be free of anxiety or symptoms which would prevent one's usual round of duties and commitments."

The character structure which renders one susceptible to neurosis has been traced by psychoanalysts to the early experiences of the child within his family. The analysis of a great number of cases has made it possible to formulate theories as to the ways in which the psychological development of the individual may take place. It clarifies the different effects of different conditions, especially the relation of the child to others and above all his parents, in shaping the finally resulting personality.

It is on these theories of personality formation derived from studies of neurosis that much of the preventive effort in the mental health field is based. Even when such effort is directed at other forms of mental illness, such as schizophrenia, they are still valid. For even in a constitutionally determined illness psychological strengthening may still help reduce the impact of the constitutional fault, if not modify the fault itself.

Psychological strengthening is of value even in the prevention and treatment of so-called physical illnesses. It is common knowledge that feelings are attended by bodily changes and that different kinds of feelings produce different bodily effects—blushing, goose flesh, palpitation, nausea, and bladder contraction are examples of this. Some organs are especially responsive to emotions. It is, therefore, not surprising to find that different habitual emotional tendencies that are established early in life are attended by different bodily changes. In fact, certain organic illnesses such as ulcer, colitis, and asthma are found to be related to the habits of feeling—habits such as fear, anxiety, hostility, anger, and resentment. These have often been termed *psychosomatic disorders,* a term which is useful provided it does not imply that other illnesses exist apart from the total functioning (feeling, thinking, and acting) of the patient.

The treatment of the neurosis may theoretically be just as varied as the factors which enter into its causation. It may consist of environmental change whereby the discordant relation between the ingrained feeling habits and the environment are interrupted. This, of course, may leave the patient unaltered and still vulnerable. Treatment, on the other hand, may focus on altering the feelings of the patient so that he may deal with the noxious situation. Psychotherapy is an all-inclusive term covering this psychiatric approach. Closely related to it are forms of personal help rendered by others than psychiatrists, such as counseling, pastoral ministry, advice, support, or the backing of sympathetic friendship. Often the environmental improvement or personal help, or both, come about by sheer accident and results in so-called spontaneous recovery. Often it is necessary to mobilize both forms of treatment designedly to the fullest and even augment them by chemical and physical adjuvants. Intensive psychotherapy, especially in the form of psychoanalysis, is a long expensive process. The psychiatrists available to carry it out are too limited in number to meet the need. For this reason there is no prospect that it can, as it now exists, become the customary treatment of the neurosis. Research and experimentation are, therefore, under way to extract from the process its minimum essentials in order that it may be adapted to more cases.

The neurosis, then, stands out as a form of mental disorder having less stigma attached to it, although possibly less heavily determined by constitutional factors than other disorders. It is the foundation for most of the preventive effort in the field. It is the bond of common interest between medical and other professions that deal with human problems.

Two other forms of disorder of high priority might have been added to these four—mental deficiency and delinquency—but their implications are brought out in special chapters.

INSTITUTIONS AND MENTAL DISORDERS

As was pointed out earlier, it is helpful to classify the deviant also by the institution with which he is associated, for it is through the improvement of the institutions that services will be improved. The titles of Chapters 4 to 14, as shown in the table of contents, give an idea of the extent of these institutions. These institutions, however, do not function as separately as this listing might seem to suggest. They are very interdependent even when no formal liaison arrangements exist. However, an enlightened state facilitates this coordination. For example, it keeps its state inpatient and outpatient psychiatric services under a common executive and maintains a close working relationship with public and private community agencies.

These agencies are all set up to deal with people who are in trouble. They encounter mental deviation in the main course of their work or as a complication of it. Many of them also contribute indirectly toward the other goals—prevention and positive mental health. In the next 11 chapters these social institutions and their concern with mental deviation and mental health will be described.

NOTES

1. Buell, Bradley, and Associates: *Community Planning for Human Services,* Columbia University Press, New York, 1952.
2. *Diagnostic and Statistical Manual of Mental Disorders,* prepared by the Committee on Nomenclature and Statistics, American Psychiatric Association, Washington, D.C., 1952.
3. *Patients in Mental Institutions, 1951–1952,* U.S. Department of Health, Education and Welfare, Public Health Service National Institute of Mental Health, Bethesda, Md.
4. Jellinek, E. M.: "Recent Trends in Alcoholism and Alcohol Consumption," *Quarterly Journal of Studies on Alcohol,* 8:1–42, June, 1947.
5. The Expert Committee on Mental Health, Alcoholism Subcommittee: *Report of the First Session, December 11–16, 1950,* World Health Organization, Geneva, Switzerland.
6. *State Programs on Alcoholism Research, Treatment and Rehabilitation,* Licensed Beverage Industries, Inc., 155 East 44th Street, New York, 1955.
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4 STATE AND LOCAL PSYCHIATRIC SERVICES

Public provision for the mentally ill has been termed "the yardstick of citizen maturity and civilization." This yardstick measures a number of responsibilities. The first consists of custody extended to protect the public against the few who are dangerous; the second, of custody to protect the mentally ill against suicide. All states measure up to these two responsibilities. These protections are legally enforced, and they suspend the freedom of the patient to provide for himself. This restriction of his freedom, however, places a great obligation on the public to provide him with the best of care. But states vary greatly in their acceptance of this obligation. As science progresses, humane care advances to include the best that medical knowledge has to offer. Relatively few patients in mental hospitals today receive this in full. Many states provide some service to patients in the community who have been discharged from a hospital or to some who may never need hospitalization. However, further measures such as research, the training of personnel, and prevention are the exception in most state budgets. They remain for the future.

The public obligation to care for the mentally ill is still, however, only a moral obligation. It has not achieved that level, voiced by Disraeli, on which charity is a right because poverty is an ailment of society as a whole. Instead, as society has protected itself and has abrogated the patient's right of self-determination, it has not established his legal right to all that science has to offer toward his recovery. Until this fact is faced no legal right will be created.

PUBLIC PROVISION

Public provision for the mentally ill was at first primarily a local (county) function and was a part of the function of the jail and almshouse. The annual report of the Ohio[1] state hospitals for 1953 refers to the difficult plight of the mentally ill under county provision:

> The founding of state hospitals for the care of the insane in the 19th century resulted from the demand of the public for more humane and intelligent care of the mentally ill, because it was realized that county care placed them on a social par with paupers and criminals, and too frequently it was a matter of self-praise for local officials who could boast that the costs of caring for the mentally ill had been reduced. In the prisons and alms houses, the mentally ill received little or no medical attention. If any was provided it was administered by persons who had no special knowledge of the nature of mental illnesses, and at best medical attention was only given in emergencies. Caretakers or attendants were generally ignorant, and often cruel and unsympathetic. The patients were housed in quarters which too often were filthy, dark, unclean and utterly unfit for an ill person, and this, coupled with cheap food, poor clothing, and no medical supervision worthy of the name made the lot of these unfortunate people miserable and sad indeed.

Beginning in Virginia in 1793 local provision slowly gave way to state asylums. Later, and especially after 1900, these asylums came to be called mental hospitals, although in practice the shift from asylum to hospital has been gradual and is still far from complete. However, the state mental hospital is now the prevailing agency for the more serious cases. Only three states continue to employ the county institution extensively for the care of such patients. These county institutions are hardly, in most instances, worthy of the name hospital, although a few of those in populous centers operate at a relatively high level. As a rule the county is too small a political unit to provide for adequate classification and separation of patients to ensure both safety and the best of treatment. Small county hospitals cannot attract a staff of high professional caliber. Beyond this, they are relatively expensive, i.e., they cost more for poorer services. By 1949 only about fifty county hospitals for the prolonged care of the mentally ill remained. Thirty-eight of these were in Wisconsin, six in New Jersey, and the remaining six in the rest of the United States. Iowa used 45 such institutions in 1949. Since then many patients have been retained on the books of the state hospital but physically transferred to county institutions. They are consequently reported as state hospital cases.

The 1949 report[2] of the National Institute of Mental Health shows 19,859 cases on the books of county and city prolonged-treatment hospitals. There were about 5,000 admissions per year, of which 4,000 were new admissions. Except where county hospitals serve as admission and temporary hospitals, their cases are, on the average, of a more serious nature and more chronic than those of the state hospitals. They are primarily custodial, and the patients can hardly be said to be under psychiatric treatment. Many are aged persons awaiting the end. Most have not responded to treatment in other hospitals and thus have been shelved to wait the benevolence of time or the intervention of undesigned recovery.

In general it can be said that the age of county hospitals has passed. They are not able to give the patients even as much of the service which science has to offer as the state hospital. With the exception of a few, they should be abolished in the interests of the patients; perhaps even those few might better be transferred to the state. Their cost to the taxpayer is out of proportion to their value. The advantage that they have of proximity to the families of the patients could be retained whether under local or state auspices. Some of them could be converted into branch or receiving hospitals attached to a large state hospital and serve as community mental health centers.

In order to bring about such an advance, however, it is necessary to understand what factors have caused these hospitals to persist. For one thing, they offer an opportunity for political patronage. It may, therefore, be expected that those who have a stake in patronage will fight for their retention. These county mental hospitals are to be distinguished from county homes or general hospitals for the permanently disabled, which will be considered in Chapter 11.

An extensive discussion of the history of the care of the mentally ill is presented in *The Mentally Ill in America* by Albert Deutsch.[3]

STATE POLICY

Only a few states have a clearly stated policy of service to the mentally ill. As a result mental institutions do not have an official guide in preparing budgets so as to provide adequate treatment for all patients. At present the intention is in most states merely implied by past budgets, and these have changed from administration to administration. Hospital administrators are thus subject to criticism if they provide only custodial care, especially if a tragedy occurs. On the other hand, they are also criticized, as impractical, if they seek to turn an asylum into a hospital. If they succeed in making rapid progress, it becomes a national event.

The state may intend:

1. To hospitalize the patient if he is a danger to himself or others—a police function
2. To hospitalize the indigent—essentially a welfare function
3. To offer hospital service to all who need it, charging according to financial capacity
4. To provide all types of psychiatric service in the community as well as in the hospital for all who need it

Differences in state policy are shown by the patterns discussed in the rest of this chapter.

PRESENT PROVISION

At the present time the differences between the states are tremendous. Some offer a minimal provision evidencing adherence to the first and perhaps, in part, the second of the policies listed above. Several states provide only one bed per 600 of the population. It is interesting that states making such low provision are also stingy in their per-patient expenditures. In contrast, more liberal states provide as high as one bed per 170 of the population. At the same time they rate the highest in maintenance expenditures. They also lead in the extension of services beyond the hospital. The factors which account for these differences will be dealt with in the latter part of this chapter. It is essential to understand these factors if progress is to be made.

THE STATE HOSPITAL

Admission. As has already been pointed out, the states vary greatly in eligibility requirements for hospitalization. When it is decided that a person requires hospitalization, certain formalities are followed. Often he is admitted by judicial procedure known as *commitment.* This is a process whereby the court authorizes the hospital to receive and hold him against his will. It is the "due process of law" called for in the Fifth Amendment of the Constitution. In some states the commitment is made so simple that the patient and his relatives hardly realize that it is a formal judicial procedure. This simplicity must, however, not be thought of as a relaxation of the protections against unwarranted denial of freedom. It is chiefly in consideration of his illness that the patient does not have to appear in court. A commitment is usually indeterminate, but it may be for a limited period of observation. Usually it lasts until the hospital decides that the patient has recovered sufficiently to be discharged. But sometimes the commitment is terminated by habeas corpus proceedings.

There are in many states simpler nonjudicial processes authorizing the hospital to receive and hold a patient. One common form requires application by a friend or relative and certification of the patient by two physicians. This certification may endure for a limited period or be indeterminate. Sometimes a briefer authorization is achieved through certification by one person—a physician, a health officer, or a police officer, either to meet an emergency or for a brief period of observation. Sometimes the patient himself is permitted by law to authorize the hospital to hold him for a limited or indeterminate period which he himself can end by giving notice of his intent to leave the hospital.

The details of these various forms of admission differ from state to state. No two states have entirely identical laws. In some states the more formal judicial commitment provides that a patient may on demand have a jury trial, even though the common concept of due process of law in such cases does not call for jury trial. In one state, Texas, such trial is mandatory in judicial commitment. In 1952 the National Institute of Mental Health formulated a model draft act[4] covering admission procedures, with a foreword by the author. This act is recommended to the states for adoption.

Of course, many mentally ill patients, especially those with less severe disorders, are hospitalized without any such formal authorization to the hospital. This is generally true of admission to a general hospital, some of the smaller psychiatric hospitals connected with universities, and some of the private hospitals. It is frequently true also of the Veterans Administration hospitals. But of course under these conditions the patient may not be held against his will.

An experiment in domiciliary care reported from Amsterdam in 1953[5] showed that many patients who would ordinarily have been hospitalized could with good psychiatric service be treated at home. It not only was more economical but made it possible to understand the patient better when he was studied in his normal social setting.

Detention and Transportation. After the authorization to hold a patient has been consummated it may be necessary to detain him locally pending his transportation to the hospital. In small states the need for detention is relatively infrequent, but in states in which the mental hospital is located hundreds of miles from the community, it is more or less the rule. At best the patient is detained in a local psychiatric facility or a general hospital. It is then possible to begin treatment immediately. In many places, however, the local jail is used. Because of overcrowding of mental hospitals such "temporary detention" may last for months even in otherwise progressive communities. As late as 1954 Allegheny County (Pittsburgh), Pa., found it necessary to end this deplorable detention in jails by providing psychiatric beds in a general hospital.

Involuntary-hospitalization laws may also authorize the transfer of the patient to the hospital. Too often the police are used for this purpose, although almost any other provision is better for such sensitive persons as the mentally ill. Extreme care is needed that the transportation to the hospital does not aggravate the patient's condition. Especially should care be taken not to deceive the patient by falsification in order to facilitate his transfer. It is important to the treatment of the patient to preserve to the fullest his confidence in his family, physician, friends, and community. The best arrangement is for transfer to be effected by the local health officer if the patient is uncooperative.

Services within the Hospital. Once a patient is admitted to a state hospital the quality of service rendered him is very variable. Even hospitals of highest repute cannot provide as much treatment as present-day psychiatric knowledge would warrant. This is not surprising when one considers that the financial support given the state hospital is from a third to a fifth of the cost of service in our best Federal mental hospitals. State hospitals often achieve high repute by focusing their efforts on cases of the greatest promise and contenting themselves with humane care for the remainder.

Ideally on admission a patient is given a prompt and thorough examination. The findings of this examination, which includes social and psychological as well as medical data, help the psychiatrist to understand how the case developed. This reconstruction is the diagnosis, although the diagnosis is often expressed in terms of a disease category, e.g., manic-depressive psychosis. The treatment plan for the patient is then laid out and pursued. It is, however, always tentative and subject to revision as study of the patient helps further to understand him and as a change of treatment seems to be indicated. The hospital is supposed to be a protected environment in which the pressures of life are greatly reduced, although recent studies show that the hospital environment may be conducive to deterioration. It should help the patient to make an adjustment, although by the same token adjustment within the hospital does not assure adjustment outside. The hospital at best therefore constantly extends its knowledge of the patient and its attempt to control the factors which induced his breakdown. To this end a social-service staff works closely with his home and community.

Ten Test Questions. There are 10 questions which may be asked about any mental hospital the answers to which will reveal the extent of its success or failure. These 10 questions are based on the assumption that a decent standard of living for a sick person in a mental hospital should be no less than that of the normal individual living in his community.

1. *Are the patients well housed?* It has already been indicated that most hospitals are badly overcrowded. Seldom are patients turned away. Few state hospitals maintain a waiting list of patients, for the condition is generally so serious that deferment is more hazardous than overcrowding. Every hospital has its official capacity on the basis of which overcrowding is calculated. Theoretically this is calculated on the number of square feet of floor space per patient, taking into account not only dormitory space but other space needed for the patient. The American Psychiatric Association has established a standard of 70 sq. ft. of dormitory and 40 sq. ft. of day-room space as a reasonable minimum provision for mental hospital patients, except that medical and surgical cases would need only 30 instead of 40 square feet of day-room space. But even considering that some states use much lower standards, the national overcrowding in 1949 averaged 18.1% and ranged up to 56%. Some states try to solve their overcrowding by simply lowering the allowance of square feet per patient.

There is a tendency for some administrators of state hospitals to blame this overcrowding on other causes than the real ones, i.e., the stinginess of budgetary provision. Most commonly overcrowding is blamed on the influx of elderly patients. The falsity of this claim is revealed in a discussion of the psychoses of old age in Chapter 3. Suffice it to say that rejection of all cases of senile and arteriosclerotic psychoses would not eliminate overcrowding. A careful review of all patients periodically would result in the discharge of some 10% if the staff and money were available to arrange for their supervision and care in the community.

Beyond overcrowding the housing of patients may be bad also because of safety, fire, and health hazards and obsolescent construction. The states themselves have rated 14% of the beds as inacceptable by a not too critical standard. But even with adequate safety provisions mental patients may be housed in noisy, badly ventilated, and ugly quarters. Federal grants for hospital construction as provided by the Hill-Burton Act have helped somewhat but have been insufficient to relieve the overcrowding.

2. *Have the patients adequate food?* Adequacy of food is measured in terms of amount, dietary balance, variety, attractiveness, and service. The fact that pellagra, formerly common in patients after admission to state hospitals, has so definitely declined among them indicates that the food given to them has improved. But the attractiveness with which it is served leaves much to be desired in many hospitals. Bad food service bears heavily on the patient's self-respect as well as on his nutrition. Also many patients need help in eating and, unless it is given, may be badly nourished even where the food is adequate.

3. *Are the patients adequately clothed?* First of all, do they have enough clothes during both the day and night? Some patients even today have no clothes. Secondly, do the clothes tend to enhance their self-respect? Are the clothes uniforms or varied? Are they neat?

4. *Is there adequate recreation?* Many patients do not get out-of-doors for months at a time. Do they instead sit idly in the wards? The provision of recreation is much more important for the mentally ill than for normal persons who can plan and provide for themselves, for as shown in Chapter 22 it serves to strengthen the personality. It is not merely a way of passing time. Many hospitals have day-rooms for patients which are useless for recreation, for with the overcrowding they are filled with beds.

5. *Is the work of the patients wholesome?* Work for patients who can work has value similar to that of recreation provided it is not drudgery. Is the work too scant, or is it excessive? Does the usefulness of the patient's work to the institution delay his discharge?

6. *Are family relationships maintained?* Are the patients cut off from their families because of the distance or isolation of the hospital? Does the hospital encourage the family to visit and maintain an interest in the patient? Failure to maintain family relations often makes it difficult or impossible to discharge a convalescent or socially adjustable patient. Many patients have been completely abandoned by their families. Many years ago the Colorado Psychopathic Hospital established lecture discussions for families as a means of increasing their cooperation. E. H. Hare[6] stresses the serious effect of isolation on mental health. He points to its demoral-

izing effect even on the relatively healthy and to the deterioration that comes to the aged patient and child when isolated in a hospital.

7. *Are patients treated as sick persons?* Above all, are they given everything that science has to offer toward their recovery? Does the number of psychiatrists, psychologists, psychiatric social workers, and nursing staff meet the standards of the American Psychiatric Association? Are those who deal with the patients trained or not? Are the patients' behavior deviations and lack of cooperation accepted as symptoms of the illness or as an annoyance? Very often second-choice treatments are used because they are more easily administered in the face of limited facilities, e.g., in schizophrenia insulin-shock treatment may be better, but electroshock treatment used instead. Psychotherapy is commonly neglected. Many hospitals are sorely in need of proper therapeutic facilities and staff.

8. *Are patients treated with respect?* Are they stigmatized because of their illness in the effort to secure employment and participate in social activities? Do they have good barbering and hairdressing facilities and is their privacy respected? Many prevailing terms—some of them legal, such as lunacy, insane, and parole—engender disrespect.

9. *Are patients protected from injury and disease?* In the community, protection is the function of the police and assault is a serious offense. What happens when a patient is assaulted in a mental hospital? Another protective agency in the community is the health service. Are the patients in the hospital adequately protected against infectious and other diseases, especially tuberculosis and dysentery? The incidence of these diseases in state hospitals usually far exceeds that in the general population.

10. *Is the mental health of discharged patients protected?* The hazards to mental health cannot be listed, since they vary from patient to patient, but they are revealed by good psychiatric study of the patient. Social service is essential to deal with many of these hazards.

The answers to these 10 questions reflect the quality of the hospital. The Group for the Advancement of Psychiatry has published a list of 315 questions that are helpful to a citizen in evaluating a hospital.[7] But unless the causes of bad conditions are known, efforts to correct them are apt to be wasteful. Six prevailing causes for poor conditions are discussed later in this chapter.

It is difficult for anyone but an expert to answer most of these questions. As a rule the staff of the hospital knows the answers and is willing to discuss them frankly with anyone who is sincere in the effort to improve conditions. On the other hand, it is also true that the executive of a hospital often becomes so closely identified with it that he does not make a distinction between his failure and that of the people (legislature) to make adequate provision. He knows also that the people are apt to make him the goat to excuse their own neglect. Sometimes it is politically expedient to praise a service no matter how deficient. Sometimes an administrator sees no solution to overcrowding and feels that the patients' families will be less disturbed and more cooperative if shortcomings are not stressed. But the more sure he is of himself, the less defensive he is apt to be. Former patients and their visitors can also help in answering these questions and provide a good evaluation of the quality of a hospital. Also the statements of patients should not be ignored simply because they are mentally sick.

The American Psychiatric Association has established standards [8] for a mental hospital. They specify the staff needed for adequate service. These standards are considered by some to be excessively high because no hospital can meet them. For example, in the New England and Middle Atlantic states the state hospitals average no better than 40% of the standard for psychiatric nurses. Other sections of the country average no better than 20%.[9] One must recognize, however, that in some other countries these standards are met better than in the United States, e.g., in Japan, where according to Blain [10] the ratio of psychiatrists to patients is 1:43 and of nurses 1:6. These standards of the American Psychiatric Association are applicable only to the large type of mental hospital. In considering the standards for a state mental hospital it should be kept in mind that most of its patients are usually ambulatory and require facilities beyond those needed by general hospitals.

One useful rough index of the quality of a hospital is its per-patient maintenance expenditure. This figure covers all costs except capital expenditures. But it must be carefully scrutinized, for some hospitals apply all expenditures in their budgets against their inpatient services even though some money may be used to support outpatient clinics. Under these conditions the per-patient expenditure is really lower than the amount reported. Also it should be kept in mind that, for every patient who is housed beyond the hospital's capacity, the state has in fact made no capital expenditure and has saved the carrying charges, which amount to about $200 per year.

The best resource for evaluating mental hospitals is the Central Inspection Board of the American Psychiatric Association. While its inspections must be requested by the state, its reports are usually, in time, available to the public. A similar resource is the survey service of the U.S. Public Health Service. This is available only at the discretion of the state authority and is not made public unless the state authorities release it.

ALTERNATE SERVICES

While the state hospital is the most commonly used hospital for the severely mentally ill, there are others. These are discussed in subsequent chapters. The state hospitals care for about 85% of the patients hospitalized specifically for mental disorders. The Veterans Administration hospitals take care of 9% and local mental hospitals of about 3%. Since there is frequent transfer of patients between these hospitals, it is to the advantage of the patients that there be good working relations between them.

COMMUNITY RELATIONS

The most serious problem confronting our state hospitals is their isolation. For the sake of their patients they need a close working relation with the health and welfare agencies of their districts, and in turn these agencies need the help of the hospitals. But the isolated hospital tends to limit its attention to the patient to the period between his entering and leaving. It does not, unfortunately, provide enough social service to bring it into closer relation to the communities in its district. Nevertheless, the best professional work demands close relations with communities from which a hospital's patients come. This is different from the public relations with the community in which the hospital is located. The public relations of many hospitals may be excellent for their immediate environs, but these may have little bearing on the services to specific patients, particularly those who live at a distance. Isolation also limits the community's knowledge of the hospital and its needs, and as a result the citizens in those communities do not take the responsibility for supporting adequate provision for the hospital.

The isolated hospital does not concern itself with the prospective patient who might be given early and effective treatment in his community. More often than not, it even terminates its psychiatric service when the patient leaves it, so that he returns home without the help of those who know him best. It is for this reason that the establishment of clinics under the same immediate authority as conducts a hospital is an important step. It ensures a broader service to patients and breaks down the hospital's isolation. It is, in fact, a logical first step in overcoming isolation. But there are other steps.

Correctives of Isolation. The hospital may provide many other community services which tend to reduce its isolation. In general they are the services which distinguish the most advanced from the more primitive state policies listed above.

1. Outpatient clinics, especially when conducted jointly with the local community and the state-hospital services (see Chapter 13)
2. Arrangements between the state hospital and local agencies for assistance to convalescent patients (see Chapter 14)
3. Well-developed social-service staff for the state hospital
4. Provision by the state of consultation to community, health, education, and welfare agencies (see Chapters 14 and 15)
5. The development of mental health centers in the community where the state's activities may be concentrated along with local mental health activities (see Chapter 13)
6. The encouragement of volunteers from the community to serve in the hospital
7. The use of boarding homes, foster homes, or family care for patients not yet ready to return to their communities
8. The development of part-time hospitalization for patients who do not require full-time hospitalization
9. Arrangements with state vocational rehabilitation services and state employment services for convalescent patients in need of these (see Chapter 14)
10. Development of an interest in and provision of assistance to communities in carrying out a program of prevention (see Chapter 15)
11. Maintenance of regular and designed public education about the hospital, its services, needs, and problems (see Chapter 24)
12. Facilitation of visiting by relatives and friends
13. Arrangements for specialist consultants in all aspects of the hospital's work, not only medical but such diverse functions as agricultural and religious counsel
14. Arrangements for staff to live in the community and be active in it
15. Liaison with research centers (see Chapter 24)

16. Liaison with centers of professional education in all fields pertinent to the hospital (see Chapter 24)

17. Exchange of assistance to general hospitals and the fostering of their psychiatric services where needed (see Chapter 8)

18. Collaborative arrangements with veterans and other Federal institutions and with other state institutions (see Chapters 5 and 15)

MORE REMOTE RELATIONS

It is not generally appreciated how dependent a state hospital is upon activities that are quite distant from it. Many students enter medical schools in states other than their own. They are then apt to practice in still other states. The same is true more or less for nurses, social workers, and psychologists. In fact, some state hospitals have more graduates of foreign medical schools on their staffs than of medical schools in this country. For much of its staff the hospital is dependent upon a nationwide market.

The extent to which these professions are prepared to deal with the mentally ill influences their readiness to go into the psychiatric service. It also affects their usefulness when they join the staff. The deficiencies of professional education account in no small measure for the staff shortages from which so many hospitals suffer. The state hospital, therefore, has a stake in the quality of psychiatric education in medical schools.

Likewise the findings of psychiatric research are almost never restricted in value to one locale but are national if not international in their implications. One finds research most abundantly supported by large foundations and the Federal government rather than by the states or communities. There are, on the other hand, notable exceptions to this in the more populous and affluent states.

Of concern to the state hospitals also are certain Federal provisions. The Barden–La Follette Act[11] provides Federal aid for the vocational training of the mentally handicapped whose work life needs direction or redirection. Financial assistance to the aged, under the Social Security program,[12] makes it possible for some old people to remain in the community under supervision or local care whose mental infirmity might otherwise require state hospitalization. The U.S. Public Health Service provides a mental-hospital survey service whereby a state may get an authoritative evaluation of a mental hospital. The American Psychiatric

Association [13] maintains a Central Inspection Board, partially supported by the National Association for Mental Health, for the inspection and rating of mental hospitals and has established an accreditation board for mental-hospital administrators. It has set standards by which the quality of a large mental hospital may be judged. In addition to its annual scientific forum it conducts a mental-hospital institute in which an exchange of experience between state hospitals is effected. It has established an architectural advisory service. It conducts also a continuous mental-hospital service through which assistance in many forms is rendered the hospital. It publishes the *American Journal of Psychiatry* and publishes notices of job openings and available personnel. This association and the National League for Nursing [14] have provided guides for education in psychiatric nursing. A professional counseling and placement service for nurses is maintained by the American Nurses Association.[15] The American Medical Association [16] examines the psychiatric training programs of hospitals and approves those that can be recommended to prospective trainees (residents) for the full three years or parts thereof. The American Board of Psychiatry and Neurology [17] is made up of members appointed by the American Medical Association, the American Psychiatric Association, and the American Neurological Association. It certifies qualified psychiatrists whom it has examined. This certification is useful to state hospitals as a guide in the selection of senior staff. The American Psychological Association [18] publishes many scientific journals and provides help in the placement of personnel, as also does the American Association of Psychiatric Social Workers.[19]

Many of these national facilities, both governmental and professional, have their counterparts in the states, thereby facilitating their availability to the state hospital. In addition there are health, agricultural, employment, and other state services of value to the state hospital. In return the hospital is in a position to provide psychiatric consultation to state agencies concerned with education, correction, delinquency, civil service, health, rehabilitation, and employment.

It is evident from this brief statement of national, state, and local facilities that the potential of the hospital which is isolated is seriously curtailed. Especially when it serves a wide territory and is located off the beaten path is it necessary for the hospital to use these resources to prevent isolation. Each resource and activity acts as a bridge to the community.

MAGNITUDE AND SOCIAL IMPORT

The state hospitals of the country are big business. In 1949 the total cost of maintenance in state mental hospitals in the United States was some $340,000,000. At any one time they are serving 600,000 patients, and the cost of service to each patient is about $900 per year. In a year's time they admit about 150,000 patients, making a total of 750,000 different persons served. But it is interesting also to see how many persons appropriate for hospital service are still not receiving help. Some 350,000 cases are estimated on the basis of studies of incidence. There are no good studies to show what is the plight of these people.

The state hospital is also a growing business, since the national population is growing and because a reservoir of hidden cases is slowly being drained. The increase is about 10,000 cases per year. This increase calls for the continuous expansion of facilities amounting to five new 2,000-bed hospitals per year for the country. The cost of this provision is estimated at $70,000,000 in new capital expenditures.

It is not generally understood that the state mental hospital is our most concentrated and dangerous focus for the spread of tuberculosis and intestinal diseases. Hospitals for tuberculosis often house more tuberculous patients, but they are better disciplined. The staff of the mental hospital shows a higher incidence of tuberculosis relative to the known cases than does the staff of a well-run tuberculosis hospital. The chance that a patient in a mental hospital in New Jersey will die of tuberculosis is twenty-five times that of the general population. This is doubtless in part the result of overcrowding and reflects a lack of even intelligent self-interest on the part of the public.

HOSPITAL STAFF

It is clear from what has been presented that the key to a good hospital is its staff. The quality of staff which a hospital is able to attract is often dependent upon the living and working conditions and the extent to which these permit a normal family or individual life. The quarters may be on the hospital grounds or in a nearby community. The latter is desirable, for a staff member residing in the community can do much to influence the public attitude toward the hospital. In either case good transportation to the hospital helps to hold the staff and to overcome its isolation. Job security, good remuneration, continued training, and recognition all add to the attractiveness of hospital positions.

As will be seen below, the staff of a mental hospital is very complex. With so many different staff members serving a patient, it is common practice to coordinate their work through staff conferences. In this way they plan treatment, assess the program, and decide on transfer or discharge. The staff conference should include those who know the patient and his needs. But participation in the conference in some places is restricted to the professional staff and has become a symbol of status.

Psychiatrists. Generally a state hospital is under the administrative direction of a psychiatrist who is its chief executive. In some instances there is divided responsibility, with a business manager having independent authority over the so-called nonmedical aspects of the program. This divided authority almost always works poorly. In general the chief executive of a hospital has assistant superintendents and a clinical director. Sometimes the business manager is an assistant superintendent.

The psychiatric service to patients is under the general supervision of a clinical director to whom all types of clinical personnel eventually report and who theoretically is in charge of the training of younger staff. In some hospitals a special directorship of training exists. The professional standing of the psychiatrist in charge of training is a factor in the ability of a hospital to attract trainees in all categories of personnel, as well as in psychiatry. Likewise a hospital that is approved for residency (training of psychiatrists) has a distinct advantage in this respect.

Hospitals in general are divided into male and female services, usually with a psychiatrist in charge of each, and within these male and female services there are further subdivisions such as admission service, tuberculosis and other communicable disease, senile, disturbed, and convalescent. The patients are divided into these classes and live in buildings and wards often designed for them. Since staff members are assigned to certain wards or parts of the hospital, it is common for a patient to undergo a change of professional staff as he moves from one ward to another. This ward-centered rigidity of the hospital is fostered by the fact that it is administratively easier that way, but some hospitals have provision for the assignment of their physicians to patients rather than to wards. The same physician then continues to serve a patient in whatever ward the patient may be placed.

Consultants. Hospitals vary greatly in their use of visiting consultants.

Some have a consulting staff to cover only those special techniques and disorders that are more urgent, such as neurosurgery. Others have a much wider range of specialists. These consulting specialists are one indication of the progressiveness of the hospital. Not only do they ensure a higher quality of medical care for the patient, but they build up and maintain the medical competence of the psychiatric staff. In return they acquire a better appreciation of psychiatric problems and the hospital's needs and serve as a bridge to the community, which reduces the hospital's isolation. Hospital staffs commonly include full-time specialists in dentistry and pathology.

Nursing Staff. The graduate nursing staff of a state hospital usually does very little bedside or direct nursing of patients. The nurse is more a supervisor and administrator. The actual nursing functions ward by ward are carried on by attendants (psychiatric aides). About 80,000 such personnel are employed in mental hospitals in the United States. Often they have little or no formal training, even though it is this category of personnel on whom the patient is dependent hour by hour. However, in some hospitals this position is given the importance that it deserves. A formal training course is offered, and those admitted to such training are more carefully recruited and selected. They also enjoy better supervision, assignment to duty, and status. This elevation of competence and responsibility is recognized by new titles such as *psychiatric aide* or *psychiatric technician,* and better pay. Since ambitious psychiatric aides are, however, not satisfied to remain in a dead-end position, steps are being taken to help them to advance professionally when they have the interest and necessary prerequisites to extend their training.

A study[20] of the attitude of psychiatric aides and other hospital employees shows that many are quite unaware of their potential for good or bad. Some fear that mental illness is "catching." Some believe that the illness is so hereditary that treatment is futile. The new young employee is less prejudiced than the older one. The study also shows that education tends to improve these attitudes.

The attendant (aide) is attracted to the state-hospital service more or less according to the security of his position as protected by a state merit system, the remuneration, and the respect accorded him. Careful selection and training help preserve these safeguards. The National Association for Mental Health has given special place in its program to the improvement of the psychiatric aide. It has expert staff available for consultation and information, distributes printed material on the subject,[21,22,23] provides awards for outstanding aides, brings this matter before professional and research organizations, especially the American Psychiatric Association, and cooperates with them in joint efforts. At the same time state mental health associations strive to secure adequate remuneration, job protection, good working conditions, and more designed training.

The Friends Service Committee and other church agencies have instituted a valuable program which warrants extension. This committee enlists men and women for service as psychiatric aides in mental hospitals, usually for a few months to a year. During this time they are offered a special course of training and education. This program has triple value: it provides much-needed personnel of high caliber, it furthers their appreciation of their responsibilities as citizens, and it establishes in the community a corps of friends of the mentally ill who can enlist public interest and support for their proper treatment.

Many hospitals have budgetary provisions for more nurses than they can secure. This problem cannot be solved by mere training of more nurses. The solution lies rather in raising the quality of the hospital so as to make it more attractive and in providing more opportunity to serve the patients. Only 5% of the nurses of the country serve in mental hospitals, but they care for 52% of the hospital patients of the country. Psychiatric nursing has not been included enough in nursing education to prepare the nurse to work confidently and comfortably in a mental hospital, nor does the hospital, as a rule, give the specialized grounding that is needed to prepare a psychiatric nurse. Too often the nursing personnel are omitted from staff conferences or otherwise given an inferior status.

The American Nurses Association and the National League for Nursing have established a Coordinating Council Special Committee on Psychiatric Nursing through which it is anticipated that psychiatric nursing problems will be studied and plans made for their correction. Corresponding state and local councils with comparable functions are prepared to deal with the more local aspects of psychiatric nursing.

Social Service. The task of the psychiatric social worker in a state hospital is to interpret to the staff the environmental conditions which may have affected the patient and may still do so, and those which must be considered when he returns home. The worker assists the family in making the adjustment to the absence of the patient and to his return and helps preserve its continued interest in him. The social worker is the bridge between the hospital and the community agencies which may have an interest in the patient and his family. Some of these agencies may keep in close touch with the patient after discharge and call in social workers when needed. By delegating a visiting responsibility to the local agencies a hospital social-work staff can maintain a closer contact with its convalescent patients who have returned home. A formal arrangement with a local public health nursing agency has aided the Marlboro (N.J.) State Hospital since its opening in the early 1930s. A report of such a service in Georgia[24] gives specific detail of the services performed.

The social worker of the state hospital supervises the patients who are placed in boarding homes. The social worker must, therefore, keep in touch with the patient and those treating him for the whole duration of his stay in the hospital.

The national professional body of this profession has been the American Association of Psychiatric Social Workers, now one of the component organizations of the National Association of Social Workers. On the average state hospitals have about one-fifth of the social workers needed as a minimum. It is, therefore, especially important to enlist the help of every community agency.

At present the social worker is responsible for more patients than can be given good service. Too often there can be little more than a periodic check-up on patients who are on trial at home awaiting final discharge. Many of the social workers are furthermore inadequately trained. Good social service is sound insurance on recovery in which the public has invested so heavily. The full potential of social service has not yet been tested. There is great need for experiments with a liberal provision of social workers to give patients a maximum of help.

Psychologists. The role of the clinical psychologist in a state hospital is as yet not so clearly defined. He often serves a dual role of assistant diagnostician and assistant therapist. In the former capacity he applies various procedures designed to evaluate the patient's capacities and functional changes. In the latter he assists with formal individual or group psychotherapy. His training fits him especially to participate in research. The American Psychological Association is the professional organization of psychologists.

Other Staff. Other personnel of the state hospital include those responsible for various adjunctive services such as occupational therapy.

A state hospital in addition to being a hospital is like a small town. It usually has its farm population, its maintenance staff of artisans, its water supply, fire protection, police, sewage disposal, power plant, transportation, and accounting departments. Some patients are employed as helpers in these departments, but too often their employment is determined by the hospital's needs rather than by their own.

Volunteers. In a special class is the hospital volunteer. The use of volunteers in general and especially in veterans' hospitals has proved so valuable that more and more state hospitals are opening up this opportunity to the ordinary citizen. In fact over 25 states are now using volunteers. Volunteers serve the state hospitals in a variety of ways, both directly with patients and as aides in other phases of the hospital operation, especially occupational therapy. Most volunteers are women, but some male volunteers find it feasible to serve outside of business hours. The volunteer should be carefully recruited, selected, trained, assigned, and supervised if he is to return the greatest value to the hospital. Community organizations such as mental health associations, Red Cross chapters, and local sections of the National Council of Jewish Women have been most helpful in recruiting volunteers from among their members. The responsibility for the supervision of volunteers should, however, be in the hands of one hospital staff member. The volunteer should not relieve the state of the responsibility for making adequate provision of personnel, but rather provide something additional. The volunteer symbolizes to the patient a much-needed contact with the normal community, and in reverse is able to interpret to the public the hospital and its needs and thereby to lessen its isolation and the public aversion to it. The National Association for Mental Health provides advice to those who are interested in planning volunteer services.

HASTENING RECOVERY

Provision should be made for periodic examination of all hospitalized patients, since the understaffing of a hospital causes patients who might be discharged to be overlooked. Psychiatric examination is also good insurance that treatable cases are not being neglected.

More conscious attention to "back ward" patients has been the subject of several experiments. The most extensive has been carried out at Stockton State Hospital in California.[25] This hospital provided therapeutic services to the fullest for a group of patients who had been in the hospital more than ten years. As a result three times as many patients were released as in a control group. In addition visits home were increased in number and duration, behavior was improved, fewer patients regressed, more patients were working within the hospital, and their general health was better. The cost was less than $3 per day extra per patient.

Another experiment in intensive service at the Topeka State Hospital likewise yielded excellent results. At this hospital a further experiment was concerned with the reshaping of the ward atmosphere, on the theory that the ward milieu must itself be meaningful and should contribute to the patient's needs. The ward was designed to be as much as possible like the community while still protecting the patient from stress. This proved highly beneficial to the patients.

At the Perry Point (Md.) Veterans' Hospital the patients are provided with special incentives in the form of paid member-employee positions. Both clinical improvement and economy result from this monetary incentive.[26]

PART-TIME HOSPITALIZATION

Most patients stay in the hospital around the clock, but for some patients the hospital offers daytime service. The patient sleeps at home but spends more or less of the day receiving such professional help as the hospital has to offer. This ensures closer family relationships. This type of day hospital has been given special emphasis and critical experimentation at the Allan Memorial Institute in Montreal,[27] Canada, and at the Menninger Foundation [28] in Topeka, Kans.

Similar in principle but reversed in operation is the night hospitalization proposed by the Institute of the Pennsylvania Hospital in Philadelphia at its opening. By this arrangement a patient may pursue a normal diurnal life, at business, etc., and enjoy the protection of the hospital and such therapeutic help as can be rendered by being domiciled at the hospital at night. An example of night hospitalization is that offered by the Montreal General Hospital.[29] The Veterans Administration has also experimented with both day and night hospitalization.[30] Both these variations in service have had the added value of serving as a bridge between the hospital and the community and thus reducing the institution's isolation.

FAMILY CARE

Another variation in hospital service is the use of the foster home, often known as *family care*.[31] Family care is most highly developed in Gheel, Belgium, where the community as a whole has a long tradition of keeping mental patients in private homes. However, nowhere in the United States has it become the dominant pattern of service. But many hospitals maintain a small family care program. Over 6,000 patients were cared for in this way in 1953 in 11 states. The justification for this type of placement is that it meets a need of the patient. Many patients may benefit by the more personal atmosphere of a home, especially those for whom the inpatient service of the hospital has little more to offer. Foster-home care well executed is not cheaper than hospital care and should not be instituted as an economy.

A study made in New York in 1942 showed that some 10% of the patients could have been placed in either convalescent care or foster homes if adequate social service and other supervisory facilities and foster homes had been available. There is need for exhaustive study, both rural and urban, to develop better methods of finding homes for patients of this type.

DISCHARGE

It is estimated that about half the patients admitted to state mental hospitals may be expected to get well enough to leave the hospital. The discharge of a patient from a state hospital is usually, as in a general hospital, simply a matter of medical decision. In some states, however, where commitment to a hospital for mental illness suspends legal competence, a legal process must be observed to restore competence. Many patients in the course of their hospital stay are permitted to spend days, week ends, or even longer periods at home.

It is common practice for patients who are approaching the point of discharge to be returned to the community as convalescents for a period of a year or so before discharge. This trial visit—or parole, as it is sometimes called—does not terminate the commitment. If the patient proves a bad risk for discharge he can be returned to the hospital without legal formality. If the trial is successful the patient is discharged and his rights are fully restored. On discharge the patient is recorded as recovered, improved, or unimproved. On the other hand not infrequently the patient has lost his contact with family and community so completely that when the time comes to go home he is afraid and resists discharge. He may even relapse at that point. For that reason the gradation of discharge through visits, part-time hospitalization, and halfway houses is important.[32]

Occasionally when a former mental hospital patient commits a crime of violence a public demand is heard for more strict regulations of discharge. A study made by New York State [33] showed that actually the prevalence of crime among such persons is only 122 per 10,000, as against 491 for the general population.

RESEARCH

A few states make appropriations for research either in the state hospital or in special research hospitals. Nevertheless, even where no provision is made, research-minded staff members often on their own or through support from other sources manage to pursue their research interests. There is undoubtedly much more research potential in the staffs of the state hospitals than is now being used. There would be still more if the positions in such hospitals were made more attractive to research-minded scientists. Research is thus caught in a vicious cycle. The scientific potential of our times is not fully used in the treatment of state-hospital patients, the staff attracted under such conditions is not scientifically motivated, and the resulting failure of research keeps the scientific potential down.

The establishment of a psychiatric-research authority for the state as a whole, and for the hospital whenever possible, could do much to break into this cycle. This has been a concern of the Council of State Governments, whose report [34] serves as an excellent guide to the advancement of research.

Research in psychiatry is by no means synonymous with research by psychiatrists. The understanding of mental illness and the devising of techniques for its treatment calls for researchers from a wide range of disciplines. Psychology, sociology, cultural anthropology, genetics, endocrinology and other branches of physiology, biochemistry, physics, electronics and mathematics, economics, and government are some of the disciplines involved. The state hospital which can establish a university affiliation has a channel to all these disciplines and a foundation for research. The veterans' hospitals have demonstrated that university partnership is mutually fruitful. A few state hospitals have established similar ties.

AUSPICES

State mental hospitals for many years operated as independent state agencies reporting directly to the chief executive and presenting a budget directly to the legislature. While in most states some centralization of the direction of the state psychiatric services has come about, still the old independence of these hospitals lingers on in spirit if not in law, except in a few states. It has been most difficult for state authorities to break down this tradition and establish in its place a system of state psychiatric services. Some states have had a succession of commissioners, each sacrificed vainly on the altar of state planning, each finding the struggle too great. Sometimes the stability of the central authority depends upon its refusal to challenge this institutional autonomy. Under such conditions there is no real state system. One measure of a state system of psychiatric services is the frequency of movement of personnel from one hospital to another in the course of professional and civil service advancement. Very few states rate high by this criterion. An excellent perspective on the conditions of the state psychiatric services and their control is contained in a report of the Council of State Governments.[35] A study of the effectiveness of the different kinds of auspices is presented by Raymond G. Fuller.[36] Among the recommendations emerging from this study are the following: The most satisfactory over-all administration of a state psychiatric service is that which is vested in a department specifically devoted to those services. The state-wide direction as well as the direction of a hospital promises most return when it is in the hands of a responsible executive rather than an administrative board. This direction and leadership in turn promises the most when it is vested in a physician qualified in psychiatry. In some states there is such a department. In many states psychiatric service is under the authority that also controls prisons, tuberculosis hospitals, and other institutions and welfare services. This has not resulted in strong consistent leadership. It is claimed for such an omnibus department that it ensures collaboration between welfare agencies. However, collaboration comes about only by functional design—not automatically by any structure. New York and California have accordingly established interdepartmental commissions which are more effective in coordinating than is an omnibus department. Even an omnibus department needs a mechanism for collaboration, for it still does not include such mental health agencies as public health and education.

The study by the Council of State Governments likewise concludes that "comprehensive mental health and hospital programs should be administered by a single integrated state agency."

BUDGETS

States vary widely in their budgeting practices. Some authorize expenditures in detail and require special permission to transfer from item to item. Some are more liberal in allowing a total sum to be spent as needed by the hospital executive. Some states appropriate the total for all state mental institutions to a central authority which in turn allocates funds to the hospitals. Some hospitals submit their requests directly to the legislature, some through the central department. In some the governor has broad power to transfer funds from one department to another. In some states the state mental health executive serves as a brake on expenditures; in others he encourages adequate performance.

SIZES OF HOSPITALS

State mental hospitals vary greatly in size. The optimum is generally considered to be 1,500 to 2,000 beds. Such a hospital is large enough to classify its patients into groups offering a minimum of complications and a maximum of efficiency in treatment. But many are larger than this. Some are larger because they serve large metropolitan centers and are located in or near them. Others are larger simply because of poor planning. Building after building is added to an existing hospital rather than face the voters with the need for an additional hospital. The state hospital in Georgia with over 10,000 beds is a startling example. If this were instead five 2,000-bed hospitals, each could be placed in a different part of the state, closer on the average to the communities and families. The impact of this proximity would help the rehabilitation of patients and the education of the taxpayer.

INSTITUTIONS FOR SPECIAL CATEGORIES

Again and again over the years states have established hospital facilities for specific categories of mental illness on the assumption that specialization ensures better service. Thus there have been hospitals for the alcoholic and the epileptic. Recently special hospitals for the aged mentally ill have been proposed. Seldom have these hospitals been able to provide better service. Some of these specialized institutions still exist; others have become generalized hospitals for the mentally ill. It seems logical to suppose that the concentration of certain types of patients in one location might concentrate the research interest and facilitate research in that particular category. Actually the limited range of psychiatric service possible in such an institution offers less incentive to professional staff and often makes it impossible for the institution to secure staff of the caliber needed to conceive and carry on research.

Epilepsy. Of the institutions for special categories those for epileptic patients have persisted the longest. It is estimated that one-half of 1% of the population of the United States is suffering from mild or severe convulsive attacks or their equivalent. The convulsive attack is dramatic. A person apparently normal in all respects is in a second changed to a writhing, unresponsive being. This change is mysterious to the layman. As a result supernatural explanations have not been uncommon. The public attitude that there is something mystical and too unpredictable about the person with this disorder handicaps him in adjusting to a normal community life. A vigorous educational effort with the public is needed to overcome this prejudice.

Epilepsy, like mental illness and mental deficiency, is not a diagnostic category, but a group of illnesses having a common manifestation: convulsions and loss of consciousness, more or less complete. Since many epileptic patients injure themselves during an attack, it was long felt that a specially designed environment was required for them. Also many of them develop personality characteristics that constitute a further handicap. Hence separate institutions have been erected.

The situation with respect to epilepsy has, however, drastically changed in the past two decades. Current medication is sufficiently effective to reduce the convulsions and loss of consciousness from 50 to 100% in two-thirds of the cases, so that most may live relatively normal lives.[37] It is now recognized that epileptic patients who need continued hospital care

are either mentally ill, and therefore appropriate for a state mental hospital, or else mentally deficient, and so properly placed in an institution for the mentally deficient. Ohio[38] in 1953 took steps to do away with its institutions for this special category, as New Jersey already had done.[39]

The Social Security Act of 1935 makes grants through the Children's Bureau to the states to extend and improve case finding and to provide medical and rehabilitation services to crippled children. Epilepsy and cerebral palsy are among the categories that may be helped through this Act.

Short-term Hospitals. Some states create special hospitals for the short-term treatable cases. Care must be taken that this move does not in effect segregate the chronic cases also. However, a distinction must be made between such a service and a generalized reception service, such as that in Bellevue Hospital in New York, which has a limit on the time during which a patient can be held for treatment. These hospitals actually receive a full range of psychiatric cases and retain for definitive treatment only those which promise a rapid response.

BASIC CAUSES OF FAILURE

An analysis of the deficiencies of state hospitals, as revealed by the ten questions, repeatedly reveals the same fundamental causes. There are about six of them:

1. Immaturity of citizen responsibility
2. Isolation of the mental hospital
3. Outmoded professional tradition and lag in professional education
4. Lack of scientific knowledge
5. Mass service
6. State poverty

It may be possible to analyze these six into even more fundamental causes, but each of the six offers a specific and practical point of attack. At the same time no more superficial attack promises any permanent result.

Immature Citizenship. In a democracy the citizens are the government. They exercise their governmental powers through governmental agencies and agents—governors, legislators, courts. As a party to the government, every citizen has an obligation to take part in it. He shares a responsibility for authorizations given his agents in providing for the public welfare, including their expenditures. As a beneficiary of government he can, therefore, claim as his right only what he has taken the responsibility for ensuring, for there is no higher political authority such as is found in a totalitarian government to grant him rights. He may find his agents and servants incompetent, but he must face the fact that he is responsible directly or indirectly for their choosing. He sets their salaries at a high enough level to attract competent incumbents, or else he fails to do so and engages incompetents. He can assign functions to his agents, such as state commissioners, but he cannot relinquish his responsibility for them.

If a state officer, commissioner, or hospital executive assumes unauthorized prerogatives or fails to keep the citizen fully informed, he in turn has violated his democratic obligations. In effect he has assumed the prerogatives of the citizenry.

A citizen is obligated to inform himself about the work of his agents and the possibilities of improvement. Whether he adopts a position of responsibility for caring for those in need is a measure of his humanity. It is an act of mature citizenship to insist on a clear state policy so that his agents may steer their course and not be allowed to drift unguided.

It is the failure of citizens to have accepted these principles and to have acted on them that has left mental hospital authorities, governors, and legislatures in a vulnerable position. They are subject to pressures to keep expenditures at a minimum. If a scandal arises the onus falls on these agents. One may embarrass them into taking the initiative to improve conditions, but unless they have evidence that the people wish improvement they cannot for long make independent decisions.

This lack of citizen maturity is the most serious and basic of the factors contributing to the inadequacy of the state hospital. Any failure of the legislature, for example, is really a failure of the people. This failure on the part of the citizen is not mere apathy. There is much more to it than that. Apathy implies an indifference, a lack of feeling. The failure is, on the other hand, full of feeling for it is so often the avoidance of an unpleasant duty. It is unpleasant because people do not like to face problems of mental illness. It reminds them too much of their own psychological imperfections. Mental illness is also unpleasant because it costs money. The avoidance of thinking about or paying attention to mental illness by the public is rooted deeply in fear and shame and is abetted by ignorance.

What can be done to hasten the maturation of the citizen? Misinformation must, of course, be corrected, and the public must be desensitized to mental illness to the point where it can study the problem with equanimity and plan improvements. One aid in desensitizing is to show how much can be done for the mentally ill, i.e., how many recover—in brief, to give hope. Often the first thought in promoting citizenship is to give lectures, distribute pamphlets, organize a discussion group, or perhaps hold a public meeting. These methods have their place. But if learning comes best by doing, it may be more effective to involve the citizen in some community project. State and mental health associations offer such an opportunity, for a part of their work is carried on by average citizens. The creation of voluntary citizens' associations is therefore a good first step in building a more mature citizenry. The National Association for Mental Health is the national voluntary citizens' body especially designed to aid a community in setting up this type of organization. The mental health association provides the citizen with an opportunity to serve as a volunteer in a mental hospital, to serve on a study and action committee, to participate in public meetings, and to use mass educational methods. It can memorialize public officials and encourage the use of citizens' advisory and governing boards. Land-grant colleges and rural communities may receive Federal grants for the support of training in citizen responsibility.

Service by a citizen on a committee of a mental health association provides an opportunity to sense the real import and power of citizenship. It entails a study of what is known about the subject under consideration, what the situation is in the community, what barriers obstruct change, and what is necessary to level them. An example of such a project is found in an article by the author on old age.[40]

Isolation. Another serious obstacle to progress by a mental hospital is its isolation. Isolation is so common as to be typical of the state hospital. Exceptionally in some states the concept of public psychiatry has gone beyond the hospital to include many extrahospital services. As a result isolation has been reduced. Aubrey Lewis[41] points out that some of the advances in psychiatric service in the United Kingdom are social rather than clinical. Formerly the government mental hospitals were somewhat isolated. Under a more comprehensive and designed health program, they have become a more integrated element in the community.

The isolation of the mental hospital is its heritage from an antecedent institution which was purposely isolated—"over the hill"—the poorhouse.

The isolation is abetted by a tradition coming from the same source: a state hospital must have a large farm, and so it must be out in the country. There is now growing doubt whether the farm of a state hospital would survive a strict cost accounting. One claim for the farm is that it gives the patients an opportunity for wholesome occupation. Actually a very small number of patients are occupied on a hospital farm, and it is doubtful whether the medical staff very often prescribes farming for a patient as a critically considered therapeutic measure. But whatever the cause of isolation, what can be its solution? The answer to this has been presented earlier in this chapter, where a list of 18 community ties for the hospital was set forth. Each of these is a bridge tending to bring the hospital closer to the community to overcome its isolation. Also if the state were to decide that its psychiatric function is to be service to people with psychiatric problems, whether that service is inpatient or outpatient, the isolation would be attenuated. Instead of a mere psychiatric hospital service to a group of counties, as previously described, a comprehensive program would include hospitals, clinics, preventive measures, rehabilitation, psychiatric assistance to community agencies, and psychiatric and mental health education both lay and professional. Instead of vesting the responsibility for this in a hospital superintendent, a director of psychiatry for the area would be needed. The hospital would be only one of his resources. This pattern of public psychiatry has been urged by George H. Preston,[42] by George S. Stevenson,[43] and by the report of a British commission.[44]

No state has constructed a program which includes all these elements. But this does not mean that such a program is only theoretical. Each one of its elements has in fact been put into operation successfully in some place. The only new thing is to bring these elements together in one program.

The main barrier to such a change is the hospital administrator. The change would either subordinate him to a broader authority or force him to become that broader authority himself, with all the administrative complications that attend a broadened responsibility. Similarly psychiatric outpatient clinics, harassed as they are by waiting lists, prefer to limit themselves to work on cases and ignore opportunities for preventive work, even though the cases reveal environmental factors which the clinic could attack.

In consequence of isolation it is much harder to plan coordinated treatment for a patient for whom several instrumentalities are needed at the same time. Of course, there are brilliant exceptions. Some state hospital administrators have been statesmanlike in their constant effort to broaden the state's psychiatric services in keeping with the needs of the people.

Professional Tradition. The third basic factor in retarding progress in our mental hospitals is the persistence of outworn professional tradition. Professional education lags behind the advances of science. Psychiatry has never been given a place either in medical practice or medical education that is commensurate with the prevalence and seriousness of psychiatric disorders. Nursing, architecture, and social service also are handicapped by this lag. The Veterans Administration hospitals have shown how a mental hospital is generally a better hospital when it also serves as a professional training center.

Gaps of Science. Every patient challenges his physician to the point where he can say, "If we only knew more—more about causes, more about treatment—we should be able to give more help." Research is the answer, but research has been poorly supported.

Mass Service. Table d'hôte special meals cost less than the à la carte. In a state hospital mass service is necessary, but it results in less choice for the patient and less recognition of his individual tastes. This is true of food, clothes, companions, and many other aspects of living. No one has found a practical way to completely eliminate the disadvantages of mass service. However, remediable deficiencies such as carelessness, e.g., in the preparation and service of meals, all too often persist. The problem can nevertheless be greatly alleviated by more adequate funds, more regard for the patient's fundamental needs, and more thoughtful effort on the part of the staff.

State Poverty. It is clear that there are important differences in wealth among the states. But poverty may be offered as an excuse for failure which is really due to other causes. In a recent year one state provided 2.2 beds per thousand population. This is only 39% as many as another state, which provided 5.7 beds. At the same time the first state spent $370 per year per patient. This is also only 39% as much as the second state, which spent $975 per year per patient. In the first state the average citizen paid 81 cents for the care of the mentally ill—only 15% of the $5.56 paid in the second state. Wealth and poverty are very difficult to measure. In terms of income the first state was credited with $1,064 per capita. This is 51% of the other state, which was rated at $2,076 per capita. The first state is certainly poorer, but there is an unexplained difference between a 15% expenditure and a 51% income. This is a problem for economists, sociologists, and political scientists to grapple with.

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5 VETERANS' PSYCHIATRIC SERVICES

Since the Revolutionary War, it has been customary in this country to accord special benefits, bonuses, pensions, priorities, etc., to those who have borne arms. Medical benefits have been included as the science of medicine has advanced. Following World War I medical service was rendered through contracts between the Federal government and local or state facilities. State hospitals provided psychiatric services at Federal expense. But this proved to be unsatisfactory. The Federal government paid for a high standard of service, but the state hospitals were adjusted to and provided a lower quality. Some states were accused of making a profit at the expense of the veterans. This problem was soon solved by the establishment of veterans' hospitals directly under a Federal Veterans' Bureau, which later became the Veterans Administration.

DECLINE OF VETERANS' HOSPITALS

Between the two world wars these hospitals failed to gain a position of influence in psychiatry commensurate with the quality of service for which they were supported. This failure was the result of a combination of forces. The hospitals took little part in psychiatric research and training. Many were located in out-of-the-way places as a result of political interests.

Immediately following a war nothing is too good for the veteran. The public is grateful. Unfortunately for the stability of these services, it is an inescapable fact that the very nature of man makes it impossible for him to maintain gratitude at a high emotional level. He tends to settle down to a comfortable state. Gratitude declines as the act for which gratitude is given becomes more remote. As public gratitude fades, the perennial demand for economy is turned on veterans' services, especially if they are expanded beyond those rendered to other civilians. It can be expected, then, that the lower level of state services will be a deteriorating force on the veterans' services. By 1940 fading gratitude was taking its toll and sharp criticism against veterans' psychiatric services began to appear.

During World War II a new force appeared. It had been rationalized up to that time that a veteran employed to care for sick veterans would be kinder to the patients than would be a nonveteran. However, the assignment of conscientious objectors to veterans' hospitals during World War II brought out the paradoxical fact that this—the hiring of veterans because they would be kinder—was an unsound generalization and was in essence more political than scientific. In fact some of these objectors went beyond the call of their jobs to make the needs of the mentally ill veterans known to the public.

REVIVAL OF VETERANS' HOSPITALS

Toward the end of the war there was a revival of gratitude. Veterans' services were replanned, and certain safeguards against deterioration were set up. As a result the veterans' hospitals soon assumed a strong position of leadership in the psychiatric field. They provided a quality of training previously found in small hospitals, especially those connected with medical schools, but rarely in the larger hospitals. In order to give a well-rounded training in both inpatient and outpatient psychiatry, affiliation was made where needed with nonveteran agencies. The veterans' hospitals trained psychiatric personnel of all types in unprecedented numbers. They brought the best that science had to offer into their clinical work (diagnosis and treatment). They enlarged that science through vigorous research. The veterans' hospitals exercised a good effect on state hospitals, which had to compete for personnel both financially and by improving their services. Large numbers of trainees of veterans' mental hospitals have joined the staffs of state hospitals and entered private practice. In fact both state hospitals and private practice have since become serious competitors of the Veterans Administration for trained personnel.

These great strides in the veterans' psychiatric services reflect first of all enlightened leadership within the Veterans Administration. But this leadership would have been less potent but for a revival of gratitude at the end of World War II.

The Veterans Administration has among other departments a Department of Medicine and Surgery responsible for all medical services. Within that department is a Psychiatry and Neurology Service through which flows the responsibility for the psychiatric services to veterans. This service has specialized staff through which constant help is given to hospitals and outpatient clinics in advancing their clinical work, training of personnel, and research.

The following policies stand as safeguards against deterioration:

1. The sanction and support of training.
2. The sanction and support of research.
3. The location of new hospitals closer to medical centers. This reduced isolation.
4. The establishment of a close working relationship with medical centers through dean's committees. This brought the best of scientific counsel to the hospital for clinical work, professional training, and research. It gave assurance of quality to potential trainees, and it gave citizen backing that has helped preserve gains. A similar connection was established with universities for the training of clinical psychologists.

The Veterans Administration psychiatric services have become something of a standard. State hospitals are beginning to see the import of these safeguards and are introducing them into state services as well. Apart from the value to veterans themselves, this impact of the rebirth of the veterans' hospital upon the whole field makes it important to protect their gains.

In practice the psychiatric inpatient facilities are of two types. Most psychiatric patients are cared for in hospitals designated for psychiatric patients, with a minimum of medical and surgical patients. Some of the mentally ill are, however, cared for in predominantly medical and surgical hospitals in which there are small psychiatric departments. There are some 39 of the former and 112 of the latter type.

THREATS OF A SECOND DECLINE

As World War II becomes more remote, gratitude will certainly decline as it did after World War I. Signs of this decline are in fact already apparent in the moves for economy and the continued pressure for political location of new hospitals. Only vigorous action by interested citizens has slowed this downward trend. But it must be expected that attacks upon research and training will be continued and that there will be further attempts to locate hospitals in remote places where they cannot be adequately staffed. If these efforts are successful, deans' committees may be expected to lose interest in veterans' hospitals and service will in that case deteriorate.

Not only is the demand for hospital facilities now beyond the supply, but it certainly will not reach its peak for many years. It is too simple a solution to try to meet this demand merely by building more hospitals. To be sure, that is a part of the answer. But when staff is in short supply it is impossible to staff new hospitals without depleting the staffs of older ones. In 1954 the psychiatric staff available amounted to 60% of the number needed for the patients under care. But there is a limit beyond which the thinning out of staff degrades the quality of work. When this limit is reached it is better to halt admissions or even to close wards. As much as one-quarter of the 10,000 psychiatric and neurological beds in the medical and surgical hospitals have on occasion been closed. The predominantly psychiatric hospitals have fortunately maintained a high percentage of occupancy of their beds.

COUNTERACTING DECLINE

New steps are apparently necessary to cope with personnel shortages. One step is to make the staff positions more attractive. Every threat by Congress of curtailment of the budget in turn threatens the security of and the continuance of professional training and research. This results in lowered morale and resignations. Special inducements for older experienced physicians to undergo psychiatric training are being offered with some degree of success.

In order to meet the need more adequately it may be possible to develop alternatives to the traditional veterans' hospital service. Within the present framework, scientific advance leading to improvements in treatment will possibly reduce the prolonged occupancy of beds. The part-time use of hospitals (day or night hospitalization, as described in Chapter 4) may stretch existing facilities over more patients. The placement of patients in foster homes (boarding homes, family care) takes up some of the pressure. Expansion of outpatient clinics facilitates and forestalls hospitalization. More use can be made of a cooperative arrangement with state hospitals and clinics provided a good quality of service is safeguarded. All these alternatives are worthy of support.

The shortsighted economizer has repeatedly made the error of reducing funds for supervision from the national and regional headquarters—both staff and travel funds. It is not realized that the reduction of supervision induces isolation and a decline of service even though the budgets of the hospitals be maintained. The effects of this "economy" are evidenced not only by loss of trained staff but also by difficulty in the recruitment of trainees.

PRIORITIES

The veterans' hospitals provide for nearly 10% of the hospitalized psychiatric patients in the United States—specifically, nearly 54,000 patients. This is the limit of present provision. But many more need this service. It is estimated that 100,000 should be provided for. Federal law has stipulated certain priorities of eligibility for this service. Most important is the distinction between service-connected illness and that which is non-service-connected. The former has the higher priority and in most hospitals, except for emergencies, admission is restricted to this group.

Veterans with service-connected disabilities take up most of the available beds, so that veterans with non-service-connected disabilities who apply for admission must be placed on waiting lists. These waiting lists are continuing to grow larger each year. At the beginning of 1955, there was a waiting list of over 16,000 veterans with psychiatric and neurologic disorders. This included over 13,000 veterans classified as psychotic. It should be noted that most of the veterans on the waiting list are currently in state or other hospitals. Veterans with service-connected psychiatric and/or neurologic disabilities are seldom if ever placed on the waiting lists.

TYPES OF PROBLEMS

The patients found in veterans' hospitals include all the diagnostic categories found in the state hospitals. There are perhaps more milder cases, and there are fewer of the senile psychoses. The greatest difference is in the overwhelming predominance of men. In fact, special arrangements with other hospitals are made so that trainees may have clinical work with both sexes.

As is the case elsewhere in medicine, so also in veterans' hospitals not all psychiatric cases are found in psychiatric wards. Psychoneuroses especially are common on medical and surgical wards and often are the primary problem of the patient. In addition the emotional reaction to a primary physical illness and the complication of physical illnesses by emotional disturbance is common. The psychiatric staff in veterans' hospitals is called into consultation frequently and increasingly to advise in these cases. Some idea of the size of this function is given by the estimate that it requires the equivalent of the full time of 38 psychiatrists and a corresponding number of psychologists and social workers. Apart from its clinical value, the educational value of these consultants can hardly be overrated.

OUTPATIENT SERVICES

The outpatient veterans' facilities are of two types, both under the authority of the Veterans Administration regional officers and, as a rule, completely separate from the hospital. One of these outpatient services, the mental hygiene clinic, is designed to provide psychiatric service to eligible veterans, i.e., those whose illness has been classified as incurred in or aggravated by military service. There are about 62 such clinics. The other outpatient facility, the neuropsychiatric examining unit, makes examinations and provides such consultation and advice as are necessary to settle claims for various benefits, especially hospitalization. There are about 72 such units.

Mental Hygiene Clinics. The present separation of mental hygiene clinics from the hospital tends to aggravate the isolation of the hospital, fragment the service to the patient, and contribute to the stigma of hospitalization. The hospitals and clinics are not administered as two treatment resources to be used alternately, subordinate to the judgment of the psychiatrist handling the case. They are so far separated administratively that no one person directs both, and the patient "belongs" to one or the other. When the patient leaves the hospital on trial he thus passes under a different authority, or if his disability is not service-connected he must depend on other state or local facilities.

Were the hospital and clinic combined into a single administrative unit, the clinic would, as is often the case in the state mental hospital or the general hospital, provide a bridge to the community which would reduce the institution's isolation and ensure better continuity of treatment. This need is well recognized, and efforts are being made to meet it. In a number of instances, the hospital and clinic have been combined and are functioning as a single professional and administrative unit. In addition there is provision for follow-up treatment of patients on trial visits at the same hospital in which the patient received his inpatient care. The fact that fragmented service to the patient is less desirable and that the patient in the hospital benefits when the hospital maintains community ties is strong argument against the placement of new hospitals in out-of-the-way places where outpatient service will not be accessible.

The outpatient treatment facilities treat about 25,000 patients at any one time, about half the load of the hospitals. This is about 5% of the 500,000 eligible veterans. The number of eligibles is high in part because of the very liberal conditions of eligibility. Any veteran who develops a mental disorder within two years of discharge is "favored" by a presumption of service connection. Two-thirds of the 25,000 under outpatient care are treated in the mental hygiene clinics. Others are given service under a contract with private clinics or practitioners. As a whole these clinics have a record of continuous intensive treatment that is probably not equaled in any other system of outpatient service. However, even in the best outpatient service or hospital a load of refractory cases tends to accumulate and increase the demands made on the resources.

The staffing of mental hygiene clinics has not kept pace with the increasing demand, so that the threat of more superficial work has constantly to be combated. Experimentation with briefer forms of treatment and other economies of professional effort have been carried forward to meet this problem.

It is of practical importance that as between outpatient service and a hospital, the hospital more readily captures the sympathy of the public and its purse. It is not fully appreciated that the clinics in many cases save the expense of hospitalization. They often prevent the aggravation of a disorder and carry the patient through crises that would otherwise result in relapse. Beyond this in some cases they reduce the degree of disability and the pension costs resulting therefrom.

Not only are the existing clinics overburdened, but their coverage is far from adequate. Large areas of the population are too distant to be served. Traveling clinic service has helped, but other ways of distributing service are needed. As state-supported psychiatric clinics are increased, it is conceivable that agreements may be made with the Veterans Administration to provide for their serving veterans as well as others.

Examining Units. The neuropsychiatric examination units provide about 125,000 examinations per year. It is considered sound practice to separate these diagnostic and rating examinations from the treatment services, for it is apt to complicate treatment if the patient knows that good cooperation and progress may result in reduction of his compensation. As with the mental hygiene clinics, some of the neuropsychiatric examining is done on a fee basis by privately practicing psychiatrists. This is an especially useful provision for patients who live at a distance from the regional office. Since the neuropsychiatric examining unit offers little opportunity for therapeutic work, many professional persons dislike this service. Special opportunities have, therefore, been developed to allow these examining staffs to participate also in the treatment of patients.

SOCIAL IMPORT

Quite apart from their direct value to veterans, it is clear that these psychiatric services have great social import. Their research has value to the whole public. They carry on chiefly clinical research dependent on, though incidental to, the treatment of patients. The research problems with which the Psychiatry and Neurology Division are occupied include the search for more effective treatment of chronic disorders, ways of measuring the improvement of patients, methods of predicting treatability, methods of evaluating treatment, discovery of causes of mental disorders, development of group tests for use in diagnosis, classification and treatment, screening devices for use by the neuropsychiatric examining units, and research in neurology. An excellent prospectus of plans for the future is presented in *A Forecast 1953–1960.*[1]

The Veterans Administration psychiatric services cost more than the public is accustomed to pay for state hospitals—about three times as much —and total some 250 million dollars per year. But the per-patient cost is still small compared with general hospital costs and far below private psychiatric hospital or outpatient services.

The social import of the veterans' psychiatric program is broadened by a policy which encourages close cooperation with community medical, educational, and welfare agencies. The Veterans Administration is interested in the improvement of state services, for there are many veterans whose needs cannot be met by a veterans' service. Close relations with state hospitals might be furthered by:

1. Assistance from the social workers of state hospitals in the supervision of patients on trial visit from Veterans Administration hospitals. This would economize on travel costs and provide the patient with supervision by social workers who are acquainted with his community and its resources. For this the Veterans Administration could afford to recompense the state.
2. The use of specialized professional staff of the Veterans Administration that is not available in the state hospital. These staff members could be made available for advice and leadership.
3. Opening up to state hospital staff and trainees the training facilities of the Veterans Administration hospitals.
4. Using the state hospital traveling clinics to bring psychiatric service to eligible veterans who might otherwise be unable to attend the more distant veterans' mental hygiene clinics.
5. Compensating state hospitals for the care of veterans with non-service-connected disabilities, just as they are currently paid for the care of those with service-connected disabilities.

NOTES

1. *Planning in Psychiatry, Neurology, and Clinical Psychology: A Forecast 1953–1960,* Veterans Administration, Washington, D.C., Mar. 1, 1953.

6 PRIVATE PSYCHIATRY

The early history of the medical care of the mentally ill in the United States is closely tied to a few mental hospitals. Among them were some private hospitals which served as pioneers and gave outstanding leadership. At that time specialized psychiatric service was rendered almost exclusively within a mental hospital. The extension of private practice of specialized psychiatry into the community has been largely a twentieth-century development.

EARLY OUTPATIENT SERVICES

Of course many mentally ill persons lived outside mental hospitals in the community, and they and their families sought medical help. But this help was given chiefly by general physicians. As neurology evolved into a specialty, the neurologist became the community specialist for the mentally ill, especially in larger cities. The scientific preoccupation of the neurologist, however, has been primarily with diseases of nervous tissue—nerves, spinal cord, and brain—rather than with psychiatry as such. For many of the neurological diseases good diagnostic criteria and techniques have been developed, but for many others the therapeutic opportunity is quite limited.

In spite of the neurologist's preoccupation with diseases of the nervous system, a large part of his practice included "nervous" patients, who paradoxically have usually no identifiable involvement of the nervous system. For them the diagnostic processes of neurology were less useful, and treatment was largely emotional or medicinal support to tide the patient over rough emotional crises or help him along a continuously rough emotional road.

While nervousness is essentially a mental disorder, patients were less prone to hide it when they were under the care of a general physician or neurologist. The stigma of mental illness is based in part on a belief that it is the result of moral failure. It is a heritage from the older concept that mental illness is due to possession by a devil. The classification "nervous" and treatment by a general physician both suggest physical causes and tend to stir up less shame and disgrace. Up to the point where admission to a mental hospital was obligatory, the community could accept the mental problem as a "nervous breakdown" or just "nervousness." Since it seldom requires admission to a mental hospital, and since it so often falls within the practice of the general physician, there is a popular belief that the neurosis is basically physical and hence not disgraceful. Therefore as long as a patient could be served by a general physician it was evidence that he was "untainted," for the "tainted" cases were passed on to the mental hospital.

PRIVATE PRACTICE

These attitudes toward mental illness are important because private psychiatric service in the community has had to overcome great odds in order to be accepted. As psychiatry advanced it was inevitable that the psychiatrist within the hospital would not be content to limit himself forever to hospital cases. When a patient improved and left the hospital, the psychiatrist inevitably was drawn out of the hospital and into the community so as to continue his treatment. Also as the science of psychiatry became better organized, the staffs of mental hospitals often devoted themselves to some private practice on the side, both as a way of augmenting income and as a way of broadening their professional horizons to take in problems that did not require hospitalization. These included both the milder psychoses and the psychoneuroses. Furthermore, many psychiatrists were drawn out into the community through serving as experts in court cases involving the question of mental competence.

An increasing number of psychiatrists found in this way that private practice was both interesting and remunerative, and many severed their connections with the mental hospitals to devote themselves exclusively to private psychiatric practice in the community.

This extramural trend was fostered by the fact that psychiatry, especially through psychoanalysis, had been able to throw new and hopeful light on the cause and treatment of neuroses. This gave the private practitioner of psychiatry a special competence in treating these nonpsychotic cases which society had come to consider respectable. The public could because of that consult the psychiatrist openly with less fear of stigma.

Even today, however, the private practice of psychiatry in the community is carried on in most places by the general medical practitioner, especially in the early or milder phases of mental illness, just as are the other medical specialties. Even for later and severe phases, a large section of the population is too remote from cities to afford specialized psychiatric service. Also it must not be forgotten that serious psychiatric cases commonly find their way to irregular and charlatan practitioners. The private practitioner is especially aware of the problem of the quack in his community, for he sees many patients after they have been put through weird ministrations by such practitioners.

For the most part the private psychiatrist carries on his practice in his own office. Many also have hospital appointments whereby they are able to continue their psychiatric service to patients in general and special hospitals. Relatively few psychiatrists visit the homes of patients to render service. Some private psychiatrists, but not many, have augmented their practice either by the employment of other professional personnel, especially psychologists and psychiatric social workers, or by forming a collaborative relationship with them.

Training for Private Practice. The fact that the neurosis looms large in the private practice of psychiatry presents a real challenge to psychiatric education. Traditionally the mental-hospital training in psychiatry includes little experience with this disorder. There is, in fact, no special preparation for private practice. The closest approaches to it have been psychoanalytic training and training for child psychiatry. Both these forms of training have been guided by a general consensus of and agreement between training centers on what training should include. Many who enter private practice with hospital experience find themselves restricted in competence in dealing with neurosis and other disorders seldom seen in inpatients. As a result they are sometimes attracted to theories and practices which cannot bear up under critical scientific scrutiny.

Costs. The treatment of patients suffering from neuroses is generally long drawn out, often a matter of years. It calls for appointments which, as a rule, extend for approximately one hour, although in some cases it is possible to work effectively with briefer appointments. Such service is necessarily costly to the patient, but this does not mean that it is correspondingly remunerative to the psychiatrist. A special study by Muncie and Billings[1] has shown that most psychiatrists charge $10 to $15 per hour. However, the number of appointments per day is too few to raise the income above the level of many other specialists in medicine whose service to the patient can be performed in briefer sessions. Psychiatrists in private practice furthermore devote about one-fifth of their time to free service. The high cost of prolonged treatment means that most patients are unable to avail themselves of private psychiatric service. Their only opportunity lies in the outpatient clinic.

Expansion of Private Practice. Subsequent to World War II there was a large influx of psychiatrists into private practice, and a definite trend was established whereby psychoanalytic training was added to the standard training for psychiatry in preparation for this type of practice. In spite of the fact that qualified psychoanalysts constitute only about an eighth of the privately practicing psychiatrists, the popular conception of the private psychiatrist is patterned after the psychoanalyst, and there is a mistaken belief that nearly all psychiatrists in training have been disciplined in this subspecialty. Blain[2] reports that about 900 psychiatrists are in psychoanalytic training at one time.

The attractions of private practice have resulted in staff shortage in many hospitals. Even hospitals in which training is given find it impossible to retain as large a proportion of their trainees as formerly. Hospital administrators are understandably disturbed by this competition. But since the competition depends upon the conditions surrounding the two services—remuneration, choice of patients, normal community life, opportunity for treatment, etc.—only by becoming more attractive can the hospitals begin to compete.

Social Contributions. Many of those who enter private psychiatry, where the problems are so largely in the area of the neuroses, tend to lose interest in the problems of mental hospitals, although their potentialities for leadership in the community in supporting improvements to these hospitals is enormous. On the other hand, they have been instrumental in encouraging the development of psychiatric services in general hospitals and often allot a part of their time, free or on a remunerative basis, to clinics. Some of them, in addition, conduct research and serve as consultants to local agencies, especially family service agencies. Many participate in lay and professional education. On the other hand, some are so exclusively absorbed with private practice that they offer little leadership in the community and in fact lack the understanding of broader community problems that is necessary for such leadership.

Private psychiatrists sometimes provide fee or contract services to other agencies. Many veterans who are eligible for outpatient treatment are able to obtain help in this way when Veterans Administration facilities themselves are too distant or have long waiting lists.

Some idea of the expansion of private psychiatry is given by the fact that in one state—Iowa—in ten years there has been an increase of 20 privately practicing psychiatrists. Almost 4,000 of the nearly 8,000 members of the American Psychiatric Association are listed as engaging in private practice. Of course, some of these practice privately only part time.

Private practice is not without its special research potentialities. But many practitioners are too busy or not interested enough to carry on research. Dunbar[3] has described some of the opportunities: to study both sick and well in a familiy, to follow up the effectiveness of treatment, to pursue psychosomatic research, to integrate all the facilities mobilized for the treatment of the patient, and to study the effect of families upon children.

The combination of community and hospital practice is professionally valuable, for it preserves the focus of practice on the patient and his needs whether he may be in the community or in an institution. It maintains a combined perspective which the more enlightened public hospitals are attempting to capture by extending their work into the community.

PRIVATE HOSPITALS

When the patient cannot be treated in the community and requires hospitalization he, as a rule, enters a public mental hospital. Only about 2.5% are found in private psychiatric hospitals. Some states place patients in private hospitals to augment their own inadequate facilities, and Alaska is entirely dependent upon a proprietary hospital in Oregon, for it has no territorial hospital of its own. The private hospitals are of two types: the voluntary, or nonprofit, and the proprietary hospitals. The distinction between these is important because the leadership in the field has come much more from the one than the other.

The Voluntary Hospital. These include the most renowned of our mental hospitals. They have held a position of leadership in psychiatry in the United States far out of proportion to the number of patients that they care for, or the size of their staffs. They are usually governed by a predominantly lay board of directors, and their work is conducted by a salaried staff of psychiatrists and auxiliary personnel. Some of these voluntary hospitals were originally proprietary, but their generous owners at some point organized a nonprofit corporation and turned their assets over to it. Some hospitals are currently in transition between proprietary and voluntary status. Some voluntary hospitals are operated under church auspices.

The Proprietary Hospital. The proprietary mental hospitals are commonly owned and conducted by a psychiatrist or a partnership of psychiatrists. Some are owned and governed by a nonmedical proprietor or by a business corporation operating through a board of directors. In any case a salaried professional staff is employed. There is great variation among the proprietary hospitals, ranging between a few that are making a distinctive clinical and scientific contribution such as Chestnut Lodge, Rockville, Md., and those which are hardly distinguishable from nursing homes.

Distinctive Features. Private mental hospitals in the United States number around 370. These hospitals care for about 14,000 patients at any one time. However, they admit about 60,000 patients per year, or over 23% of all admissions. This means, of course, that they have a very rapid turnover of patients. The turnover is in part explained by the more acute nature of the cases admitted. They receive a much higher percentage of acute alcoholic patients than do the state hospitals, and many patients are admitted for a short time for thorough study and intensive treatment. Many patients are thus discharged in a few weeks. Also private hospitals receive a lower proportion of patients with senile and arteriosclerotic psychoses, who tend to remain somewhat longer. The turnover of patients is increased by the inability of many families to bear for long the costs of a private hospital. As a result many patients are transferred to public (state) hospitals. The death rate in private hospitals is about half that of state hospitals. The lower intake of the aged in part accounts for this fact.

Costs. One distinctive characteristic of the private mental hospital is its higher ratio of doctors to patients. The costs extend upward, as a rule, from the levels of cost found in good general hospitals, depending upon the luxuries that are provided in addition to the essential psychiatric services. But when one considers that the state mental hospitals operate on the average at a cost under $3 a day per patient and the veterans' hospitals at least as low as $8, the costs of the private hospitals become quite striking.

Social Contributions. The private voluntary hospitals hold an enviable record for public service. They have contributed greatly to professional training. Some of them have university affiliations or are integral parts of medical schools. They have engaged heavily in research and thereby have contributed to the supply of research personnel.

Control. When states take a responsibility for licensing, supervising, and inspecting private mental hospitals, usually this task is vested in the same authority as governs the state hospitals. However, in most states there is no such safeguard, and the private hospital is less fortified against suspicion and criticism of irregularity in the admission of patients. The suspicion that such irregularity (railroading) is common is not justified by known instances of improper detention. Such instances exist, but the anxiety of the public to safeguard its freedom greatly exaggerates the danger. At the same time there is an opposite concern that patients may be released too easily and become a public danger. The exercise of supervisory authority by the states is very desirable. But, as has been indicated in the summary and recommendations of the Council of State Governments:[4] "Few state mental hospital authorities have sufficient supervision and control of private mental institutions. Such supervision is essential if patients are to be assured of proper care and treatment and protected against hazardous surroundings and illegal detention. *All private mental institutions should be under unified supervision by the appropriate state agency.*"

NOTES

1. Muncie, Wendell, and Edward G. Billings: "A Survey of the Conditions of Private Psychiatric Practice throughout the United States and Canada," *American Journal of Psychiatry,* 108:171–172, September, 1951.
2. Blain, Daniel: "Private Practice of Psychiatry," *The Annals of the American Academy of Political and Social Science,* 286:136–149, March, 1953.
3. Dunbar, Flanders: "Research in Private Practice," *American Journal of Psychiatry,* 107:739–742, April, 1951.
4. *The Mental Health Programs of the Forty-eight States,* The Council of State Governments, Chicago, 1950.

7 THE U.S. PUBLIC HEALTH SERVICE AND NARCOTIC ADDICTION

Within the U.S. Department of Health, Education and Welfare are many mental health activities. Some of these are a part of the programs of large nationwide bureaus—the Public Health Service, the Office of Education, the Office of Vocational Rehabilitation, and the Social Security Administration, including the Children's Bureau. In addition this department includes St. Elizabeths Hospital, which serves certain mentally ill persons for whom the national government has a responsibility. This hospital also provides service, corresponding to that of a state hospital, for the mentally ill of the District of Columbia. The department also helps support Howard University, which offers training for mental health and through its affiliate, the Freedmen's Hospital, provides clinical psychiatric service. These bureaus will be considered in their appropriate contexts. This chapter deals specifically with the psychiatric facilities of the U.S. Public Health Service.

Since 1798 the United States has given medical service, including hospitalization, to its merchant seamen. This in fact was the beginning of its public health service. But over the years its clientele has expanded to include coast guardsmen and their dependents, coast and geodetic survey officers and crew members, and certain personnel of the Public Health Service staff. It provides psychiatric observation for some Federal criminal cases pending trial or sentence. It receives some immigration cases and Federal employees injured in line of duty.

In 1929 a Narcotics Division was established. The following year it was renamed the Mental Hygiene Division. In 1939 the division added a mental-hospital survey service whereby a state could secure a study and evaluation of its mental hospitals. This service had been given previously on a small scale by the National Association for Mental Health. The National Mental Health Act of 1946, sponsored by the National Association for Mental Health, greatly expanded the functions of the Mental Hygiene Division and led in 1949 to the reorganization of this division as the National Institute of Mental Health.

This institute is located at the research center of the U.S. Public Health Service at Bethesda, Md., just outside Washington. Shortly after the passage of the National Mental Health Act in 1946, responsibility for compiling the annual census of patients in mental hospitals and institutions for the mentally defective and epileptic, which had been borne by the Bureau of the Census, was transferred to the Public Health Service. Its reports are the main source of reliable data about mental hospitals and institutions in the United States. The research center of the National Institute of Mental Health is also located at Bethesda, along with the other National Institutes of Health.

Under the National Mental Health Act, the National Institute of Mental Health receives applications and makes grants for research to other research centers throughout the country. It also makes grants for professional training, especially of psychiatrists, clinical psychologists, psychiatric social workers, psychiatric and mental health nurses, and research personnel. It makes annual grants to the states for the development of community mental health programs.[1] These grants are made on a formula basis, and the state is required to match each $2 Federal with not less than $1 state and local funds. In approving the research, training, and community-services grants, the National Institute of Mental Health is guided by decisions of a National Advisory Mental Health Council, which in turn is assisted by groups of experts in training, research, and community services.

The inpatient clinical psychiatric activities of the Public Health Service include chiefly the psychiatric departments of the U.S. Public Health Service general hospitals, psychiatric service to the Federal prisons, and the facilities allotted to the National Institute of Mental Health at the clinical center for research at Bethesda. The Public Health Service in addition has many separate outpatient services.

U.S. PUBLIC HEALTH SERVICE HOSPITALS

The U.S. Public Health Service provides a total of 2,421 psychiatric beds in general hospitals, such as those in New York (Staten Island), Baltimore, New Orleans, San Francisco, and Seattle, and the hospitals largely for drug addicts at Lexington, Ky., and Fort Worth, Tex. These hospitals differ among themselves as to type of patient they serve. Some are primarily for continued-treatment (chronic) patients, whereas some others are for intensive treatment in acute cases, and the remainder a combination of the two. The intensive-treatment centers have a very rapid turnover of cases. All these psychiatric centers are sections of general medical and surgical hospitals. In addition the psychiatric staff give abundant consultation service on the medical and surgical patients. These hospitals also use the same staff to conduct very active outpatient clinics. The outpatient service is motivated especially toward the prevention of hospitalization through intensive treatment.

These hospitals constitute a very small part of the national provisions for the mentally ill, but their importance is disproportionately great. The quality of service rendered ranks among the highest and sets a good standard for public psychiatry. They maintain both a professional training program and a research program. Of course, the cost is correspondingly high, but it is difficult to calculate accurately because psychiatry is not budgeted separately from medicine and surgery and also because the inpatient service is not budgeted separately from the outpatient.

The 90-bed unit on Staten Island, N.Y., is a good example of this high standard. Its staff includes some who have already qualified in psychiatry but are receiving advanced training, as in psychoanalysis, through the conveniently located facilities of New York City. The staff includes a full-time clinical psychologist and a full-time psychiatric social worker. In addition to the social-work functions performed by the social-work department of the general hospital, the staff is very active in the Staten Island community. It provides leadership in the local citizens' mental health organization, participates in preventive activities, and assists in the mental health program of a local college.

These hospitals are known to only a very limited portion of the public even in the cities in which they are located. As a result the support for adequate appropriations and the continuance of their high quality cannot come from citizen activity. The method of budgeting for their support is not entirely satisfactory, since it is dependent upon the allotment of a specified sum of money per occupied bed. This does not take into account the greater cost per bed in an intensive-treatment unit where rapid turnover of cases takes place. Also certain expenses continue even when a bed is unoccupied. Nor is the lack of an outpatient item in the budget an incentive to develop the outpatient clinic. It is to the credit of the staff, its morale, and its professional status that this deficiency has not seriously affected the service rendered.

The Public Health Service Hospitals at Lexington, Ky., and Fort Worth, Tex., are specialized psychiatric facilities. They are the main centers of the United States for the treatment of narcotic addicts, although they receive also some 10% of general psychiatric cases. These hospitals provide both training and research. The National Institute of Mental Health Addiction Research Center located at Lexington has greatly advanced our knowledge of habit-forming drugs and their effects, and methods of treatment and rehabilitation of the drug addict. These hospitals admit some 5,000 cases per year; the numbers would be higher but for the overcrowding which forces many applicants, especially women, onto a waiting list.

NARCOTIC ADDICTION

Since drug addiction is, as a rule, clandestine, it is not unexpected that drug peddling is a part of organized crime. The addict usually lacks legitimate sources of money to buy drugs and is forced into all kinds of illicit money-raising practices. Among these is selling the drug to other addicts and encouraging new users.

In another way also addiction participates in a vicious cycle. Psychiatric studies of addicts reveal in many cases that the addict has had a seriously impoverished childhood emotionally. There has been a paucity of affection, especially within the family. His life as a result is governed by a struggle to find at least what he has lacked in childhood, an affectionate relationship. But the distortion which his personality has suffered makes it hard for others to give him that affection that he craves. In its place he gets rebuff after rebuff only to confirm him in his wariness of others. He settles instead for transient and shallow companionships, the gang, the transient cohabitant, the partner in addiction. Addiction has the added attraction of dulling his disappointment. In such cases it cannot be expected with confidence that a termination of the use of narcotics will be more than transient unless a successful resolution of this basic psychiatric disorder is achieved through psychiatric and social treatment. Laws controlling narcotics and narcotic addicts are necessary, but they are not a solution in themselves. Only a public alert to the social conditions that contribute to human degradation can change these basic factors. Individual treatment clinics in the main centers of addiction are desirable both for early treatment and as indicators of the presence of more basic social problems.

MIGRATION

Especially vulnerable to psychological damage are those families who emigrate in great numbers from radically different cultures even within the United States itself. As a result they live in homes and neighborhoods where the supporting value of a stable culture is shattered. The Public Health Service has been eminently successful in arresting the spread of communicable disease through immigration but has provided less safeguard against mental disorder. In the early part of this century, the National Association for Mental Health gave special attention to the psychiatric screening of immigrants who hitherto had been admitted almost indiscriminately. But its success in this venture came at the point of decline in immigration. There is still need today for the protection of the mental health of the migrant by services at both ends of his journey.

FEDERAL PRISONS

An enlightened form of public administration is exemplified in the cooperation between the Public Health Service in the Department of Health, Education and Welfare and the Federal Bureau of Prisons in the Department of Justice. It is the type of interdepartmental cooperation that could be taken seriously elsewhere in Federal as well as in state and local governments. It allows a division of labor and administration based on technological expertness, while at the same time it respects the integrity of the person served to the point that the services are tied together before being rendered.

The Public Health Service has for a quarter of a century provided medical and health services, including psychiatric and psychological, to over 30 Federal penal institutions. Its professional training and research in these units have resulted in significant contributions.

THE RESEARCH CENTER

The clinical center at Bethesda, Md., differs from the above services in that it is motivated primarily toward research rather than clinical service. About 100 of the 500 beds are assigned to the National Institute of Mental Health. It has a research staff qualified in practically all the disciplines bearing on mental health and is equipped with extensive laboratory facilities.

NOTES

1. *State Mental Health Programs as Planned for the Fiscal Years 1954 and 1955,* U.S. Department of Health, Education and Welfare, Public Health Service, Washington, D.C., September, 1954.

8 PSYCHIATRY IN THE GENERAL HOSPITAL AND GENERAL MEDICAL PRACTICE

The histories of patients who are admitted to mental hospitals show that they have already been served by a variety of community agencies. The type of agency that they call upon is usually determined by their symptoms rather than by their underlying disorders. If the patient is preoccupied with philosophical and moral quandaries, he is apt to seek help from a clergyman. If he imagines that enemies are after him, he may go to the police, or they may apprehend him if he tries to retaliate. In the same way many of the mentally ill have physical complaints that bring them to the attention of physicians and general hospitals.

But if the general hospital recognizes that a patient is a psychiatric case it usually refuses to admit him. It, therefore, to that extent is not really a general hospital, for the treatment of mental and emotional disorders is a part of the general field of medicine. Fortunately enough general hospitals have provided psychiatric service successfully to prove the feasibility of admitting and treating these patients.

TYPES OF PATIENTS

There are at least three types of cases in which the patient can be given psychiatric help in the general hospital. First, there is the patient with a severe mental illness. It is often necessary to detain such a patient in the community pending admission to a mental hospital. Sometimes admission is delayed because of legal formalities (commitment) which are seldom required for admission to a general hospital. Sometimes the mental hospital is far away, and unless the patient can be placed in a general hospital temporarily, his recovery or even his life may be risked by holding him in the local jail. It may aggravate the patient's distrust of those close to him—his family and his doctor—and block their efforts to treat him. Sometimes the need for admission to a mental hospital may be in doubt, and a period of observation in a local general hospital may resolve that doubt and give assurance to the family. Many patients are committed legally and taken to a mental hospital far from home when a brief period of prompt intensive treatment in a general hospital would have sufficed.

The lack of psychiatric service works to the great disadvantage of patients who develop serious mental symptoms while in the general hospital. Delirium often accompanies acute infections and metabolic disorders. In such cases immediate intensive treatment is generally effective. Obstetrical patients not infrequently develop transient mental disturbances after delivery, as do surgical patients after operations. These should be treated with the least possible disturbance. To transfer them to the state hospital, sometimes in coma, entails great risk. But again and again these delirious postoperative and post-partum patients are transferred because the general hospital is not equipped with facilities or staff to meet their needs.

But the general hospital has an even greater value for a second group whose deviation is less severe. By conservative estimates in 20 to 25% of the cases admitted to general hospitals a mental and emotional disorder is the basic problem. Few of these patients are seriously disturbed, but the treatment needed is primarily psychiatric. Sometimes, in cases of neuroses, admission to a hospital which refuses psychiatric cases is made possible only by subterfuge. The doctor obscures the presence of a mental disorder by emphasizing only the physical problem which is so often present also. Research in recent years has shown how often high blood pressure, colitis, asthma, headaches, gastric and duodenal ulcer, and many other "physical" illnesses stem from chronic emotional disturbance and require psychiatric treatment as well as medical or surgical attention.

In a third group, also comprising 20 to 25% of general hospital cases, the emotional disturbance is secondary. It either aggravates the physical illness or threatens to complicate its treatment. Sometimes in turn the physical illness may aggravate a susceptibility to emotional disturbance which previously had been kept under control.

Quite apart from meeting the needs of psychiatric patients, psychiatric service in a general hospital increases its appreciation of personal and situational factors in all illness. Every patient comes to the hospital with anxiety, not only about his illness but about the disruption in his routine of living, his business, his family, and his social life. Doctors and nurses who are more sensitive to the psychological and social aspects of the patient's life are surer of his cooperation and can contribute more toward his recovery. Especially is this the case with children. In fact, lasting damage may be done to a child who is separated from his main source of strength and security, his family, and at the same time threatened with an operation or other treatment which to him means pain and danger. This is brought out clearly by Winkley,[1] who kept in close touch with the home in order to achieve a fuller understanding of the child and fuller range of opportunity for tiding him over a tonsillectomy.

RELATION TO MENTAL HOSPITAL

The general hospital is a logical ally of the mental hospital. The partnership between the state mental hospitals and the communities they serve is strengthened if the local general hospital is able to help mental patients both before admission and after discharge from a mental hospital. A general hospital is also a good location for a state hospital's outpatient service. Therefore both the inpatient and outpatient psychiatric facilities of the general hospital serve as a bridge from the community to the state hospital and help overcome the hospital's isolation. In turn liaison between the two makes it possible for the small rural general hospital to add to its staff a visiting psychiatrist from the state hospital. In this way certain patients could remain nearer home, or if they were transferred, the state hospital would not need to repeat the full examination. A state may be encouraged as a matter of policy to permit its mental hospital staff to serve as consultants to general hospitals. Even further, the state might emulate the Veterans Administration and compensate the general hospital for service which the state would otherwise be forced to render.

California by law has authorized counties to maintain psychiatric facilities and services in local public or private hospitals for emergency care or observation. Patients may be treated in this way on court order for a ninety-day period, or voluntarily. This provision tends to reduce stigma and returns many patients to the community without their having entered the state hospital.

EDUCATION, RESEARCH, AND EXPERIMENTATION

There are other unfortunate consequences to the failure of general hospitals to embrace psychiatry. Many of these hospitals provide training for interns, resident physicians, visiting staff, physicians of the community, nurses, and members of other auxiliary professions. The hospital that provides no psychiatric service provides a deficient training and perpetuates the resistance of physicians to psychiatry.

A general hospital which accepts psychiatric cases is thereby educating the public to a better attitude toward these disorders. Both the staff, including volunteers, and its governing board become proud of their enlightened policy and convey this attitude to the public.

The refusal of the general hospital to include psychiatric service retards scientific progress. The emotions of the patient and the conditions under which he is living affect his visceral, muscular, metabolic, and secretory activity—in fact, all aspects of his bodily function. The hospital that has no interest in its patients' daily life is apt to ignore it in its research. In fact such a hospital is apt to have a rather sterile social service—more clerical than professional—or none at all, and so its records will lack important social data.

While much is still to be learned, the provision of psychiatric service by general hospitals has passed its basic experimental phase. Any hospital can now follow a well-beaten course. More and more general hospitals are providing this service. For example, within a ten-year period six general hospitals in Iowa added a total of 131 beds for psychiatric problems.[2] One report [3] lists 818 hospitals that claimed—too often without warrant—psychiatric facilities as of December 1953. Nevertheless it is significant of the trend that many claim more than they really provide. Especially have psychiatric departments become the rule in the large municipal general hospitals. The scientific literature on the development of psychiatric service in general hospitals is now quite extensive. Outstanding has been the work of Dr. A. E. Bennett,[4] who has an extensive bibliography to his credit.

CONSTRUCTION

Much also can still be learned, but much is already known about architecture, costs, interdepartmental relations within the hospital, staff needed, and relations with outside agencies. The U.S. Public Health Service has developed suggested floor plans for psychiatric units which may be used by architects in designing hospitals. These include plans for units of different sizes and for units serving different types of patients, such as the quiet or disturbed.

The Hill-Burton Act authorizing Federal grants-in-aid to the states for hospital construction has established policies which encourage the provision of psychiatric quarters in the general hospital. However, while some hospitals have included these facilities, they still do not accept psychiatric patients, nor have they the staff or equipment to treat them. It is, therefore, important to encourage the hospital-construction authority in a state to bring about the activation of these psychiatric facilities. It is not uncommon now for several counties or communities to join together in establishing a general hospital. Here is an opportunity to introduce a psychiatric unit in the plans before prejudices have become fixed. Such communities are often remote from any special psychiatric facility.

INTEGRATED SERVICES

However, while desirable, it is not essential that a hospital have a specially built psychiatric unit before liberalizing its admission policy. One of the pioneer psychiatric services in a general hospital is that of the Ford Hospital, in Detroit, where for three decades it has been demonstrated that most patients can be cared for in the usual private rooms of a general hospital.

Some hospitals which do not have a special psychiatric unit have added a psychiatric social service, psychiatric nursing, and more recently psychological and consulting psychiatric staff competent to deal with psychiatric cases encountered in their regular medical, surgical, obstetrical, and pediatric services. Psychiatric consultation may in fact be the best beginning. From that point on, progress is apt to be spontaneous. The experience of such hospitals as Strong Memorial Hospital in Rochester, N.Y., Norton in Louisville, Ky., Michael Reese in Chicago, Mount Zion in San Francisco, and Mount Sinai in New York, have demonstrated the effectiveness of a small beginning with the accent on quality. These hospitals have the advantage of full-time psychiatrists and have influenced the development of similar services throughout the United States.

PREPAYMENT PLANS

Just as many general hospitals discriminate against the psychiatric patient, so also do some of the prepayment hospitalization plans. Some are frankly antagonistic, but others argue that they cannot provide for the mentally ill if the hospitals with which they hold contracts do not accept such cases. But there is also the fact that some prepayment authorities identify mental illness as a chronic illness and on that premise disqualify all mental illness whether in the specific case it is acute or chronic.

The noncommercial plans are often prohibited by law from including tax-supported hospitals in their programs. Some plans seem, however, to have been able to circumvent this restriction. Most plans which do provide for mental illness do so only through private general hospitals. Of course, the plans vary greatly from community to community. The benefits to the mentally ill range from complete exclusion to the provision of 70 days of hospitalization, or 21 days of full and 180 of half coverage per year. Nevertheless, there is encouragement in the progress that is being made. In one year (1951–1952) six Blue Cross plans added mental illness to their coverage. By 1953,[5] 22% of plans provided full benefit on the same basis as other illness; 40% provided partial benefits, out of a total of 81 plans. An extension of coverage in 1955 provided for mental disturbances, chronic alcoholism, and drug addiction.

OVERCOMING DISCRIMINATION

Why this discrimination against psychiatric service? The answer is complex. To a certain extent it reflects a reluctance to face a "disagreeable" problem to which stigma is attached. It is fear that mental patients may get out of hand. It is fear that they may cost so much that they will increase the hospital's expenses. These reasons produce resistance in boards of trustees, in patients themselves, and in the general public.

But when the medical staff objects there are also other reasons. There is often keen competition between the specialties for hospital beds. In addition, a large part of the medical profession has received entirely inadequate preparation in psychiatry. They are, therefore, embarrassed to admit that this is an essential part of medicine. This resistance appears not only in the general hospital, but throughout medical practice. The plight of the general physician in relation to psychiatry will be considered further shortly. The attitude of general physicians toward psychiatry is by and large the most potent deterrent to the acceptance of the mentally ill in general hospitals.

However, communities vary. In any one place it is important to know exactly where the obstruction lies and how great an obstruction it is. To this end the attitudes of trustees, staff, patients, and the public need to be studied. The establishment of psychiatric service in general hospitals is closely dependent on the local lay and professional leadership. The county medical society can be very helpful, since the facts can be brought before it for discussion and action. In Chapter 2 the steps that may be taken in developing such a service were presented in detail as an example of planning.

TRADITIONAL MEDICAL PRACTICES

The opposition of doctors to the inclusion of psychiatric services in general hospitals has its counterpart in the private practice of medicine. General physicians and specialists outside psychiatry have tended to ignore the existing scientific knowledge about human behavior. The family physician of old depended upon his intuition to sense emotional problems and to help the patient to reach an emotional adjustment. In fact his scientific limitations were such that often his main value was psychological. Over the years he was likely to become quite successful in dealing with the psychological and situational factors in all illness, and he thereby rendered real help to his patients. The development of "scientific" medicine then drew the physician away from this psychological function and narrowed his perspective to the laboratory and organs and the pathology of tissue. The psychology of the emotions had not advanced to the same extent as anatomy and physiology. The general physician struggled vainly with psychosomatic diseases and disliked them. He was constantly frustrated, because the crucial emotional component was left out of account. The patient, vaguely aware that something was missing, shopped around from doctor to doctor in search of relief. In fact the patient often found in the quack a person who displayed interest in him as a total person, emotional as well as physical, even if—or perhaps because—the quack had no scientific training. The poorly informed public responded favorably to the quack's imaginary simplifications of human function. The doctor's neglect of the patient's personal and situational problems gave aid and comfort to the quack.

The narrowing of medical perspective was fostered also by the evolution of medical specialization. The specialized physician focused on a diseased part of the body or on a system, such as the respiratory or digestive system. It now very often seems as if the physician had forgotten that a lung or a stomach never comes to him without a patient attached to it. As a result of this narrowing, many personal and situational problems that affect the patient are not even discovered, and their impact in producing the illness, complicating it, or interfering with its treatment is not taken into account. Emotional problems are consequently allowed to worsen until very often they become the patient's main disability. As a result the clientele of the physician includes many unrecognized cases of emotional disorder. The number has not been accurately assessed, but it is estimated at 25 to 50%.

ADVANCES IN PSYCHOLOGICAL MEDICINE

Over the past few decades experiments have confirmed and broadened our knowledge of the inseparability of the emotions and bodily processes. Of course experiments were not necessary to prove that goose flesh, pounding heart, and dry throat are signs of emotion. But the laboratory has now put these on a scientific basis and made them a "respectable" part of medicine. Medical education now includes more about human behavior and more respect for the wholeness of the patient. This is offered to the student through his courses in pediatrics, gastroenterology, and other branches of medicine, as well as psychiatry. Medical vision is now broadening in three directions:

1. Physiological changes are seen regularly to accompany emotions.
2. The behavior of people is recognized as just as fundamental a subject for and just as amenable to the scientific processes as the behavior of tissues and organs.
3. The study and treatment of life situations of patients—environmental, occupational, cultural, familial—are viewed as basic and scientifically valid aspects of sound medical practice.

The doctor who uses this broadened science finds himself less baffled by some of his chronic cases. He not only depends more on collaboration with the psychiatrist but practices some measure of psychiatry himself, just as he practices in some measure all the other specialties. Encouraging indications of this expanding medical horizon are seen in the numerous seminars conducted in many of our larger cities by psychiatrists for general practitioners. Specially prepared textbooks, bulletins, and articles in general medical journals have been published to help the general practioner and nonpsychiatric specialists carry out effective psychotherapy for those patients for whom referral to a psychiatrist is not indicated or, for other reasons, not feasible.

The doctor is also concerned with the personality differences in patients and the way these bear on their disorders. He is more aware that illness is the result of a conspiracy of factors and that a small event may trigger a sizable disorder in a person who is sensitized by previous life experiences. He is less dependent on and restricted by rules and schedules in dealing with the disorders of babies and is more attentive to the emotional atmosphere of the family in which the baby is trying to grow up.

These are the gains that are being made by the newer crops of our medical schools. The problem is to help the older crops to catch up.

In any case vigorous effort is needed to overcome the public and professional resistance to the inclusion of psychiatry whether in a general hospital or in outpatient practice. There are, of course, the usual processes of public education. But especially worthy is the organization of a volunteer service in mental hospitals. The volunteer can speak from experience about patients unnecessarily admitted to mental hospitals, patients who might have been served better at home by a better-equipped physician or by a local general hospital. Also a constant watch can be kept on the use of jails instead of general hospitals for the detention of mental patients, for this practice highlights the discrimination against the mentally ill.

NOTES

1. Winkley, Ruth: "The Case-worker's Participation in Preparation for Tonsillectomy in Children," *Mental Hygiene,* 37:430–440, July, 1953.
2. Iowa Mental Health Authority: *Second Biennial Report, Ending June 31, 1952,* p. 11.
3. *General Hospitals with Psychiatric Facilities as of December 1953,* U.S. Department of Health, Education and Welfare, Public Health Service, National Institute of Mental Health, Biometrics Branch, Bethesda, Md.
4. Bennett, A. E., M.D., 2000 Dwight Way, Berkeley, Calif.
5. Special communication from Blue Cross, Feb. 26, 1953.

9 PROVISIONS FOR THE MENTALLY DEFICIENT

There are two essential elements in mental deficiency. First, the mentally deficient person is socially incompetent. Second, this incompetence is due mainly to a deficiency of intelligence. Deviation in intelligence per se is no more a sign of a disorder than is height. Some people are tall, some short, and others in between, and there are jobs in which each can excel. But some are too tall or short to find suitable jobs easily. Some are tall or short because they come from tall or short stock. Others, on the other hand, are short or tall because of a bodily disorder.

THE MEANING OF MENTAL DEFICIENCY

So it is with intelligence. Intellectual giants may have a superior capacity for sensing obscure relationships and for dealing with abstractions. They may show brilliance, imagination, wide understanding, and knowledge. At the other end of the scale are the mentally deficient, dwarfed intellectually by a great variety of causes, some genetic, some accidental. Their reasoning and capacity for abstract thinking are too limited to carry them through the ordinary demands of life. They must depend, therefore, upon a person of good intelligence to make judgments and perhaps decisions for them.

Mental deficiency, therefore, is based on social incompetence rather than a physiological or psychological standard. While this criterion is not precise, since it varies with the demands of society, still it serves well except at the border line. With a rise in social demands, the sufficient person near the border line may become inadequate, or as demands are eased the deficient one may carry his own weight. A shift from city to country, from single to married life, or from childlessness to parenthood may be enough to throw a person of limited intelligence over the border line of social sufficiency. Gibson and Butler[1] have pointed out that cultural changes can depress a borderline case to the level of mental deficiency. Mental deficiency accordingly denotes a disabling discrepancy between demands of society that are reasonable for most people and the limited intellectual capacity of a certain person.

In some instances the intellectual defect is, however, so great that even the most favorable life situation cannot balance it. Conversely for others of higher, but still very limited, mental capacity who have failed in the face of exceptional stresses the classification of mental deficiency may not be appropriate. This point was the subject of special discussion in Chapter 3.

Sometimes a person of slow development may be falsely classified as mentally deficient, especially at the border line. Children develop at different rates. Some reach their maximal growth sooner than others. Late maturing or a spurt in the teen years may upset predictions that had been based on previous slow progress. It is hazardous, therefore, to classify a person as mentally deficient until his growth potential is known.

The rigidity of a school system also confuses the classification at the border line. If the school does not provide a curriculum that is suitable for a borderline or slowly developing child, it may force him into a special curriculum for the mentally deficient. In that case it is really the school that is deficient. This schologenic mental deficiency accounts for an unduly high incidence of mental deficiency among school children. After leaving school, however, many of these children find suitable work and make a reasonable adjustment.

All these variables and uncertainties about mental deficiency highlight the importance of careful psychological research and clinical service. They explain why a great part of the significant advances has come from the psychological field.

EXTENT

Less than 2 per cent of the population is usually found to be mentally deficient. The greatest number of these is concentrated just below the border line, with the prevalence decreasing as the deficiency becomes greater. Because of this concentration of cases at the border line, small differences in the social situation may seriously affect the count of cases. The determination of the extent of mental deficiency in a community by testing and counting cases is a research of major proportions. It is expensive and fraught with many obstacles to accuracy. Unless it can be done soundly, it is just about as accurate and satisfactory for practical purposes to calculate 1% of the population as mentally deficient. According to Robert Gibson,[2] a deficiency of intelligence is found in some 70 diseases. Some of these, such as mongolism, are practically always accompanied by mental deficiency of varying severity. In others, such as cerebral palsy, intelligence is at times well preserved. In some categories the typical case is seriously deficient. In others most of the cases have a moderate deficiency of intelligence, while in still others most of the cases are mild and found just below the border line of normality. The prevalence of only a few of the categories has been worked out satisfactorily.

Variation in Cases. Each medical diagnostic category has its own causes, peculiarities, outlook, and treatment. This means that generalizations as to prevention, research, and the training of personnel are apt to be unsound.

The official classification of the American Psychiatric Association provides for only two groups of mental deficiency—hereditary and familial disorders, and disorders due to undetermined cause—and each group is subdivided into mild, moderate, and severe. This is a superficial classification for convenience and does not represent any fundamental psychiatric distinction. However, the mild-grade cases tend to be distinctive as to family background. These individuals are more likely to come from families which themselves are not highly endowed intellectually, whereas in the moderate and severe cases the families tend to be fairly representative of the whole population. These are, however, merely group tendencies and an individual case may not follow the tendency at all. Since three-quarters of all the mentally deficient are in the milder group, this family tendency seriously complicates the early recognition of the problem. Not only are the families likely to be less perceptive, but since the cases are milder their recognition calls for the greatest acuity. This points up the need for better methods of case finding in the community. Brown [3] has reported on cases of mental deficiency from a middle-class suburban community: "Most of our children come from homes of low social and economic status. . . . Five families have contributed two children each to our program; three have given us three each; four boys and a girl came from one family, and three boys and three girls from another. Eleven of our number have been from foster homes."

The identification of the mentally deficient has been somewhat obscured recently by the use of the term "mental retardation" in place of "mental deficiency." In the past each of a succession of terms has had its day—fool, idiot, feebleminded, mentally deficient. Each of these is etymologically innocuous but has eventually acquired connotations that make it unpleasant. If this discarding of a term were accompanied by actual scientific advance it might help to escape the connotations. But the change merely of a word tends to obscure only temporarily these unpleasant connotations. In fact this obscurement has been the purpose of the change. The use of the term "mental retardation" is especially confusing because for decades it has been applied also to children who have done poorly in school because of limited intelligence but who are not mentally deficient.

Some of the confusions in this field are, however, signs of progress. At the turn of the century the mentally deficient were considered a clear-cut and distinct group because they included chiefly the obvious and severe cases. These cases were considered suitable only for permanent custodial care. At that time also it was believed that a mentally deficient person could propagate only the mentally deficient. Psychological case studies bringing to light the border line have, however, shown how unrealistic these clear-cut concepts were. The discovery of the borderline case, while confusing, really represents a great step ahead, for there is no sharp dividing line from normality. Also the identification of many clinical types of mental deficiency promises a better future for the mentally deficient.

Many persons unfamiliar with mental disorders are unclear about the distinction between mental deficiency and mental illness. But on the contrary the psychologist or psychiatrist sometimes makes clearer distinctions than the facts warrant, with the result that the mentally deficient are treated as if they were not subject to the same emotional forces as other people. Still the chief opportunity for helping the mentally deficient may lie in dealing with their emotional difficulties.

The layman can often be helped to understand the difference between mental deficiency and mental illness by recalling his school days. He will remember that some students could get a straight A more easily than others, whereas some were constantly slow and trailed their age group by several grades, although eventually they may have made a good adjustment under less rigid and demanding conditions of adult life. He can understand that the extreme of this academic difficulty constitutes mental deficiency. But he also knows that some students did poorly because they were worried. These pupils may even at one time have showed brilliance and academic success. They are the ones who "have brains but don't use them" because their emotions interfere. The extremes of these cases are the mentally ill.

SERVICES TO THE MENTALLY DEFICIENT

Preceding chapters have dealt with the agencies which provide service to the mentally ill on the ground that it is through changes in these agencies that improvements in service will come about. This principle holds to a degree for the mentally deficient, but there are differences that make it seem worth while to focus this chapter on the problem of mental deficiency rather than the institutions which are set up to deal with it.

Usually the mentally deficient are a lifelong concern of society. This concern extends from the need for prevention beginning before conception, through prenatal care, early case finding, diagnosis and treatment, and training and education during the period of growth. It continues into the vocational life of the mentally deficient and ends, as a rule, in dealing with the dependency that comes in old age. The success of society in meeting the needs of each period depends upon its concern for every other period, even though that period may come years later, e.g., it is impossible for the school program to be well planned unless the potentialities of adult life are taken into account.

But these concerns have not in fact existed. Some needs are completely ignored. Where services exist, they exist with almost complete disregard for each other. There is no over-all design. Neither communities nor states—nor, in fact, the country as a whole—make comprehensive plans of service for the mentally deficient. They do not begin by outlining the life needs comprehensively and then when that is done allocate the labor for the different technical aspects of the plan to appropriate technical agencies. Instead every agency plans its tasks first and then fails to fit them into an over-all plan. This is typical of society that works on a problem at first piecemeal, in isolation, expediently and palliatively. The urgencies of mental deficiency have kept society at work on the pressing needs, trailing behind the demand. It has not been able to raise its head above the problem long enough to get a better perspective on it. As a result the agencies designed to serve the mentally deficient need a thorough rethinking, replanning, and overhauling based on the functions to be performed. It seems better, then, in this book to keep a full perspective on mental deficiency by including all the specialized services to the mentally deficient in a single chapter.

Prevention. The first service to the mentally deficient is prevention. Prevention is postnatal, prenatal, or preconceptual, for by definition mental deficiency exists from birth or from a very early age. It is easy to understand that a condition that is symptomatic of some seventy medical diagnoses will have a variety of causes and could not be prevented at any single time by any single process.

Cases in which the hereditary factor is essential can be prevented chiefly by preventing conception in those who are likely to procreate the mentally deficient. Some of the most severe mental deficiencies are due to a cataclysmic and probably transmissible change in the genes. Since the offspring are unattractive they seldom reproduce, but the girls in this group must be especially protected. However, the girls with higher-grade mental deficiency of genetic origin are more prolific. In these the hereditary process itself may involve no abnormality of the genes. These cases are merely the less endowed offspring of a family of inferior intelligence. In such families the prevention of conception is more difficult because the deficiency is less obtrusive and goes unrecognized by the family, even if sensed by the community. Also it is not certain in the minds of many people how far the control of conception should extend or at what level it should end. Since it brings up the possibility of contraception and sterilization, it is a problem that is complicated not only with technical but with moral and religious positions.

Prenatal prevention is concerned with a quite different group of cases. The most clear-cut opportunity lies in prevention of rubella (German measles) during pregnancy. While it is a mild disease, rubella is apt to be most dangerous to the child when it occurs during the early months of pregnancy, and it has been proposed that young women be immunized by exposure to the disease prior to pregnancy. Cases of cerebral palsy may be prevented by improved obstetrical service, including special caution in anesthesia of the mother at delivery, and regular prenatal supervision.

Preschool Period. The first need of the mentally deficient child is a thorough medical and psychological examination and evaluation. This should not await the attainment of school age, although such delay is common, especially in mild cases. It happens also because parents find it hard to accept the possibility of mental deficiency.[4] It happens because doctors have had little training in the diagnosis of mental deficiency or in helping such children. The medical evaluation usually does not take long, although in some cases prolonged observation is needed.

It has been found that in many cases it is possible for the family to fulfill its responsibility to the child if it has the skillful guidance of a special worker who can visit the home and give parents the counsel and support which they need.[5] The medical evaluation is often the first step in planning for a mentally deficient child and in preparing parents to accept their problem and to deal wisely with it. Skillful help to the family during the first few years does much to ensure a maximum of success for those who try to help the child later.

In addition to a thorough medical evaluation it is important periodically to assess the child psychologically. This is accomplished by psychological tests and observations. The intelligence level of the child may be expressed in terms of mental age, i.e., the age of an average normal child of equivalent intelligence. It also may be expressed as a percentage of the intelligence which the child would have achieved had he developed normally. This is the intelligence quotient (IQ). But a thorough psychological examination analyzes the mental make-up of the child, estimates his learning ability and extent of his progress to date, and provides a foundation for his care and training.

It is hard to find good institutional service for mentally deficient babies and young children. Since congregate provision for babies is hazardous at best and the mentally deficient are often especially vulnerable, institutions prefer older cases. The proper facility for babies is a babies' hospital rather than a school, for the need is for general mothering, protection from infection, good medical evaluation, and the provision of whatever treatment medical science has to offer, even though little therapy is possible.

During the first half of this century many clinics were established throughout the United States for the treatment of behavior problems of children. But too often these clinics have looked upon children with mental deficiency as untreatable and have refused to accept them. Still leaders in the field of mental deficiency, such as Fernald early in the century, recognized that psychotherapy is an important resource.[6] More recently a special study at Pacific State Hospital (for the mentally deficient) in California[7] has shown that psychotherapy increases the rate of discharge of patients with IQs of 40 to 70, that lower-grade patients can be returned to the community, and that apparently unpromising cases can be rehabilitated. If this is the case in the institution, it is more so in an outpatient service.

The family of the mentally deficient child which is not weaned from the belief that he can be made normal may squander its resources by going from specialist to specialist, only to find itself unable to provide adequately for care and training later. Care is needed in advising parents, for they tend to magnify any prospect of improvement. Their inability to face the child's deficiency is shown by the way they avoid even the term mental deficiency. This is understandable and should be dealt with sympathetically but not encouraged.

The use of euphemisms for mental deficiency is quite common. In the 26 advertisements of schools in one issue of the *American Journal of Mental Deficiency* the following terms were used:

Retarded children
Mental defective
Mentally deficient
Mentally retarded
Slower child
Retarded girls
Exceptional children
Exceptional children
Mentally handicapped
Exceptional children
Backward
Atypical child
Retarded and borderline
Unable to keep up with academic requirements
Minds have not developed normally
Children who do not adjust themselves happily
Retarded and mongoloid
(Complete avoidance of any term)
Mentally retarded children
Exceptional child (slow, nervous, retarded)
Children requiring special methods
(Complete avoidance of any term)
Backward and mentally deficient
Backward and mentally deficient
Retarded and exceptional
Educational, emotional, or speech problems

The most promising trend in many decades has been the organization of associations of parents of the mentally deficient. Hand in hand they are able to face their own problems more realistically and plan for better services for all.

SCHOOL AGE

To meet the numerous demands of life the mentally deficient need to use every bit of their intellectual potential. They have none to spare. Not only must their meager talents be identified and developed to their fullest, but the emotional matrix from which intelligence is inseparable must be healthy.

The Emotional Factor. The child's emotional development must support, or at most not burden, the fullest use of his limited intelligence. This degree of emotional stability is an ideal seldom achieved, for the mentally deficient live in a world of normal expectations, normal demands, and normal pressures, because of which they are under constant emotional stress. The community's best adjustments to the mentally deficient at school or at work are far from perfect. They are too much determined by the needs and capacities of the normal. They are seldom custom-made for the deficient. Even the most successful, the most loving, the most understanding and adjusted home cannot fully buffer the crudities of the world beyond the home which is not loving, understanding, or adjusted to mental deviation. The talents of the mentally deficient, meager to begin with, have to carry the extra burden of emotional disturbance incited by an intolerant world. If the child is spared some of this outside harassment in his early years, it is apt to be at the expense of being impoverished by overprotection at home. His fullest emotional growth demands other social relationships than those of the family. He needs other children to play with. But to compete with normal children means failure and damage to his emotional development, and so he is trapped between the distorting effect of an unsympathetic world and the stunting effect of isolation.

The younger child can be helped to meet this need by an especially designed nursery school as a prelude to school life. After that the school is society's main resource for fostering his intellectual and emotional development.

THE PUBLIC SCHOOL

Of all the mentally deficient from birth to death, some 15%, i.e., those of school age, go to school in their own communities. Some are identified as such, whereas others, especially the high-grade case, are not. The identification is better where special provision is made, i.e., in larger communities.

Even though a school may not examine all children routinely, it still has normal children to stand as a base line against which to judge whether any child deviates seriously. It can thus follow up a suspicion by more precise methods of psychological examination.

Having identified the case of mental deficiency, the schools are confronted with the need to accept the child. Unfortunately many schools instead of making special provision exclude the child and seek his admission to a state school. This is an act of public irresponsibility, for the great majority of these children will grow up and work in the community. One of the values of the school is to help them to adjust there.

Accepting a child in school, however, is only a first step. It does not guarantee that the schools will give him relatively as much of what education has to offer as they give the normal child. It is not generally appreciated how much can be saved in terms of both human and economic values by adjusting the school program to the child's needs. Society has made varying provisions for deviations in intelligence within its schools. Sometimes these provisions are formally designed, and sometimes they are individual adjustments that are made by the individual teacher. The latter come about more easily and more naturally in the small rural school, where the teacher is used to making adjustments for different age groups in one classroom and is apt to know the child's family and surroundings. Traveling supervision or consultation by experts in the education of the mentally deficient can do much to help such teachers.

Too often the teachers of special classes have no special competence beyond elementary teaching. Some teachers' colleges provide special preparation for teachers of the less severely deficient. However, almost no special preparation is available for teachers of the more severely deficient, whose needs differ as greatly from the less severe group as the latter do from the normal.

Where the schools make formal provision it is usually through special classes for the mentally deficient. This not only permits a specially designed program and equipment and specially prepared teachers, but it gives the child relief from competition with normal children. In 1933 L. Pierce Clark,[8] who devoted years to the emotional characteristics of the severely deficient, pointed out the importance to the deficient child of following his own tempo rather than that of the normal. He indicated that the additional amount that the child can absorb "must vary only slightly from what has already been taken in; there must be slow advance and constant review. But above all, love must be given by the teacher and won from the child in order to overcome the primary narcissism and induce a projection toward identification in a wider field."

Many school systems have established special classes for the milder grades of mental deficiency, roughly those with an IQ above 50. Through these classes children have been helped so that in adult life they contribute significantly to their own support. But it is estimated that schools provide for less than a quarter[9] of the mentally deficient of school age, and for most of those the provision is inadequate. These special classes are seldom designed according to the functions which the child will be fulfilling after leaving school, or even according to his current needs and potentialities. Schools do not periodically study children after age 20 to find out how they are living and working. Such follow-up is a continual need, since the work and home life of the adult varies greatly from time to time and from community to community.

Most of the severely deficient children never go to school. The failure of society to meet the needs of the low-grade mentally deficient may be summed up specifically in terms of teachers poorly trained, classes too large to allow for individualization, and school facilities neither designed nor equipped to meet the needs. For them special classes are a rarity. New York City has only 30 such classes, and they are rare elsewhere in the state. Ohio provides state aid under which about eighty classes had been established by 1954 in 22 counties. Most other states do less well. Where special classes exist they are often equipped with castoffs completely unsuited to their needs. The greater age range in these classes calls for provision for different sizes of furniture, by design, not by chance. The smaller children should not have to peek out above their desks, nor the larger ones sit on them instead of on the seats.

Many a mentally deficient child is excluded from school not by a formal act of the school but by its failure to provide a form of education that can hold him. As a result he often becomes a chronic truant. The educator who has been unable to get the public to provide special facilities for such children often concludes, perhaps wisely, that the child will have a better chance if no issue is made of his nonattendance provided his time is being spent profitably. On the other hand, truancy is hazardous, for it is often the entree to delinquency. The time comes in the middle teens when the child who is confronted with chronic failure in school takes the first opportunity to leave school legally and go to work. He then comes under a new set of regulations within the community and state—those concerned with safeguarding the young worker. He is subject to the same laws, regulations and enforcements, working papers, supervision of employment, etc., that apply to all his age group. His problems are, therefore, of interest to the Bureau of Labor Standards of the U.S. Department of Labor and the corresponding state agencies which are concerned with young workers.

Social Philosophy. The quality of special education for the mentally deficient is, of course, influenced by the total school philosophy as it bears upon the mental health of all children. For that reason it is suggested that this discussion of education for the mentally deficient be read along with Chapter 19. The more seriously mentally deficient are usually excluded from school by a semantic twist whereby they are classified as uneducable. But those who have dealt with even the very low-grade mentally deficient know that they are educable in the sense that their behavior can be changed for the better by providing them with carefully designed experience. Criticism of provision for the mentally deficient is not an indictment of the teaching profession. To make the teacher a scapegoat will solve nothing. The failure reflects a social philosophy that the mentally deficient person has little inherent personal worth and is to be treated only as a burden. Consequently society does not find the money and the legal sanctions that are necessary to give all the benefits that the profession of education has to offer. Special provision for the milder cases costs about 25% more than provision for the normal. This is a small investment when one considers the cost of neglect. There is hardly a phase of education where an investment is likely to pay some profit as surely as good education for this group. One need consider only the community problems of health, dependency, nonproductivity, and delinquency that follow the neglected child as shown by Buell[10] to sense the potential of good education.

The issue is therefore not essentially a technical one as to whether these children are educable. It is a deeper philosophical question—are all human beings worth while in themselves, or are there some who are expendable because their contributions to society are limited? The problem is not one of adjusting the curriculum to those who deviate far from the normal, for schools make that adjustment for highly intelligent children who deviate just as far. The community would not for a moment consider them inappropriate for schooling. Society pays a higher price than it realizes for its philosophy of expendability of the less endowed.

The exclusion of the mentally deficient raises the question of whether the school is a service to the children of the community to aid them in their present development and in their preparation for the future, or whether it is simply an academic instrument. Leading educators consider schooling an opportunity for the child to live in a way that will be currently satisfactory to him and basically strengthening. The mentally deficient need this service as much as anyone, even though their academic potential may be very limited.

The parents of the mentally deficient, of course, are one group of citizens who do not subscribe to a philosophy that these children are expendable. By their own efforts they have in many places made up for the failure of the community by establishing their own facilities privately. But this is only an expedient. If the needs of all the mentally deficient are to be met, this expedient must be accompanied by leadership which will raise the level of self-interest, if not the humanity, of the rest of the community and result in services for all. Associations of parents seem to be doing just that.

THE STATE SCHOOL

One large piece of this unassembled and incomplete jigsaw picture of service to the mentally deficient is the state school. The state school tries to perform three technically quite different functions. This circumstance may account for the fact that in general it does none of them satisfactorily.

It tries, first of all, to be a medical agency whose job it is to evaluate thoroughly the medical status of the mentally deficient individual. A good medical service results in the determination of the diagnostic category of which the mental deficiency is a manifestation. It brings the patient to the point of maximum medical benefit, so that the degree of apparently permanent disability can be ascertained as far and as soon as possible. In this way the individual's education can be planned, and his work life can be established within his outside limits. The medical task includes general medical and pediatric services. It also includes obstetric service, for some girls are pregnant on admission. It includes, in addition, participation in the education of personnel, research, and preventive medicine.

Secondly, the state institution tries to be a school. This means that it must determine the educational potential and achievement of the pupil and provide the professional service that will bring him to the point of maximum educational benefit. To do this it must anticipate the personal adjustment he will need to make and the work life that will be available to him in the community. If he cannot return to the community, it must prepare him for life in an institution that will provide him with an opportunity to use his potential as fully as is feasible. The educational function of the state school also includes research and the training of personnel.

The institution in addition to being a doctor and teacher finally tries to provide benevolent, indeterminate custody in which life is enjoyed to the maximum and useful work is performed. In other words, it tries to be a family, a neighborhood, and an industry. In terms of number of cases this is the major preoccupation of the state school, but paradoxically it is the function for which there is the least scientific foundation. Under present conditions the custodial function grows and grows, crowding and hampering both medical and educational functions. The Wayne County Training School in Michigan is an exception, for it has been protected from this accumulation of custodial cases by evacuating them to other state institutions when its medical and educational goal has been reached. It has as a result been able to give exceptional attention to both research and professional training.

Inadequacies. Since the school tries to perform a threefold function, opinions differ as to whether it is a medical, educational, or industrial agency and whether it should be directed by a physician, educator, or businessman. Most states adhere to the first viewpoint, but it is quite clear that no one of these types of directors has been adequate to bring this complex of functions to a full realization. A new pattern seems to be needed. As was pointed out in the report of a survey in North Carolina,[11] "schools for the mentally deficient in general have not attained the standard of patient care and treatment afforded by hospitals for the care of the mentally ill." This is a severe criticism, considering the deficiencies of our state hospitals.

A step in this direction appears in a New York State report:[12] "The Commission strongly recommends that the supervision of educational services provided for handicapped in state and county institutions be the responsibility of the Education Department. Such responsibility should include the certifying of teachers, developing curricula, supervising classes, and otherwise providing services for the children in all these institutions in like manner, amount and quality as is provided by the Department for such children in public school classes."

Some measure of the present scientific status of these schools is found in their annual reports. The record of a patient in even a poor hospital includes a medical diagnosis. But the reports from institutions for mental deficiency include some 30% or more of cases frankly listed as undifferentiated. Even the differentiated cases include some such nonmedical categories as "familial." In fact, in only about 15% of the cases is there a diagnosis expressed in terms that would be found in a regular medical nomenclature.

The failures in the educational function of the state school are analyzed by Levine[13] who finds that

> Inadequate appropriations are made for educational needs; school buildings are poorly designed and equipped; there are too few well trained and interested teachers; they are isolated from outside agencies and specialists; pupils are regarded as patients; facilities are not complete from nursery school to continuation school; there is a lack between the educational and vocational programs; low and middle grade cases are inadequately planned for; leisure time activities are neglected; there is neglect of emotional growth, socialization, and development of habits and skills that will make the child a worthwhile citizen; there is insufficient literature written specifically for the mentally deficient; there is no agreement on an overall program or curriculum; education is too much dominated by institutional expedience; research is inadequate; many institutions are more custodial than educational; the public is not aware that the mentally deficient can be educated; the rigidity of the institution unfits the child for community life; there is insufficient community supervision; state universities neglect this phase of special education.

While the attitude of the public has much to do with the neglect of the mentally deficient, this attitude is abetted by the isolation of the state school. It may in fact be suspected that the state schools are allowed to be isolated because the public is more comfortable when they are out of sight. But isolation is vicious because it hampers the return of successfully trained and treated individuals to the community, and in addition it is discouraging to the staff of the institution.

The deficiencies of state schools militate against their securing good personnel. Doctors and teachers with high qualifications, enthusiasm, and inquisitiveness are hard to attract. Even more the deficiencies undermine the morale and produce a high turnover of staff, for as with any organization the higher the quality of top staff the less will be the turnover and the higher the morale throughout. This has been emphasized in a study on the problems of employee morale by Hill.[14]

Admission. State schools at present carry about 10% of the total cases of mental deficiency. This includes a higher percentage of the lower-grade cases, in which the medical and educational potentials are more limited. What percentage of the cases an institution would carry if it were integrated with the community and a part of a grand program no one can say at present. Both children and adults are admitted to state schools. Of these many of the children will remain only temporarily for training and will then be returned to the community. Others are expected to be permanent custodial cases, although theoretically this prospect is always tentative.

The mentally deficient are admitted to a state school by a legal process very similar to that used for admitting a mentally ill person to a mental hospital. But unlike the mental hospital, the state school in many states tends to restrict its resident cases to a certain number. When the demand exceeds that number a waiting list is established. It can do this because mental deficiency is less frequently an acute emergency than mental illness and because the public is less afraid of the mentally deficient. However, in most states there are "ways" to expedite admissions where an emergency exists. For less urgent cases the wait may be a year or more, during which time valuable opportunity is lost. If the neglect is long and serious enough the case may take a turn for the worse, e.g., delinquency, and thus gain admission; on the other hand some who are listed for admission make an adjustment in the community. Recognizing this, some states have tried to give medical and education services to those awaiting admission.

The waiting list is, however, not simply a reflection of limited institutional facilities. It reflects also the attitude of many health, education, judicial, and welfare agencies in the community which do not want to make the adjustments necessary to serve these children. One can figuratively hear a sigh of relief when a "difficult case" is found to have an IQ below 70, for this supposedly is a ticket of admission to the state school and an opportunity to shed the problem. The waiting list is thus not an unmixed evil. It constitutes a pressure on the community to apply itself more vigorously to adjust to the case. Anyone who is concerned with the improvement of state services, therefore, cannot escape the need also to improve the facilities in the community.

An essential goal of a training school is to return to the community those who can be adjusted there. Readiness for discharge is shown by the adjustment of the patient within the institution and by trial visits to the community. The school should itself provide supervision for those who return or arrange for it through local agencies. The latter type of supervision has advantages, for although a local supervisor may not be expert in the field, he is more continuously available. Subsidy of the local agency for this purpose by the state is justified, and the social-service personnel of the state school can serve as expert advisers and consultants to the local agency.

Apart from special considerations the quality of medical, educational, and custodial service rendered by a state school varies within about the same limits and for the same reasons as the state hospitals, and the same questions can be asked as a test of its quality as were suggested in Chapter 4.

A special commission in New Jersey[15] has reported significantly on the conditions in that state and has made recommendations. The findings of this commission have special import, since they reflect conditions in a state which has occupied a more advanced position. Its report focuses primarily upon the school-age child. It found that most cases have escaped identification; that lack of planning has resulted in permanent incapacitation; that in institutionalized cases the children receive little training; that home training is promising but underdeveloped; that state appropriations are meager; that in many known cases the children are unserved or improperly placed; that institutions are overcrowded; that personnel are in short supply and training facilities woefully inadequate; that institutional and community services are uncoordinated with each other or within themselves; and that the associations for retarded children have been a stimulating force. It urgently recommended two more institutions conveniently located; better salaries, opportunities for promotion, and living conditions for employees; training scholarships for employees; expansion of home training; responsibility for education in the community by the State Department of Education, in institutions shared by the Department of Education, and the department conducting these institutions; a central state registry for all cases; a state-supported research program; and a state coordinating agency. They recommended in addition state-financed public education for the mentally deficient; courses in mental deficiency in professional schools; periodic evaluation of the state program; codification and revision of laws; special provision for the defective delinquent; reasonable case loads for supervision; extension of halfway colonies for patients employed in communities; provisions in the institution for training, occupation, recreation, and religious observances; training courses for employees; study of the professional services of institutions; reimbursement of parents who make provision privately for lack of public school facilities; review of the method of charging families for patients in state institutions; liberalizing of admission to state institutions; improvement of discharge and supervision procedures; providing institutions with sufficient social workers to give supervision; providing vocational rehabilitation; utilization of civic organizations in developing community services; strengthening of the role of the church in service to mentally deficient by better training of clergymen; and establishment of better clinic facilities to find cases and provide treatment.

PRIVATE SCHOOLS

Much that has been said about private mental hospitals in Chapter 6 is true of private institutions for the mentally deficient. They also are either proprietary or nonprofit. The nonprofit institutions have provided leadership in research, technical methods, and philosophy. It is the leadership of these schools that makes them important far beyond the number of cases which they serve. In fact in 1951 there were only 6,247 cases on the average in private institutions. The services that these institutions render tend to be of higher quality than those provided by the state. The cost of these services in schools is accordingly high compared to the state schools.

The quality of private schools varies greatly. Some are dominated by an atmosphere of warmth and individualization. Others are more concerned with training which glosses over the child's defect. Sometimes to satisfy parents they impose luxuries and embellishments of living on the pupil to a point that unduly complicates his life. The maximation of the atmosphere in which the child counts most is expressed by one school in its slogan: "Happiness First—All Else Follows." Excellent discussions of the private schools from the parents' standpoint are found in an article by Pearl Buck [16] and in a book by John P. Frank.[17]

Some of the private schools have recently broadened their admission policies to include not only the mentally deficient but children with more or less serious emotional problems. This is to a degree only a formalization of existing practice, for both public and private institutions have long accepted cases of "mental deficiency" which in fact should be classified otherwise. Some are obscure cases of childhood schizophrenia.

THE COURT

Reference has already been made to the fact that the mentally deficient are of interest to the court. The courts authorize their admission to state institutions, and they must deal with many mentally deficient who have been neglected to the point of becoming delinquent. The role of the court is often transient, but in many cases persons are held on probation for long periods. In either case the court needs to understand the mentally deficient and the facilities that are available to help them. This kind of knowledge is not, however, commonly included in the curricula of law schools, so that courts must either perform their functions by intuition or call upon expert assistance, if such is procurable. The presumption of wisdom on the part of the court sometimes impedes an appeal for outside help and forces the court to make unwise decisions. Even a successful effort to bring the court to a better understanding is of transient value, because juvenile court work is seldom a career but rather a mere steppingstone in the progress of a lawyer in the public service.

Probation officers are more fortunate, for they are apt to continue in probation work. But they are often untrained, or if trained they have received a very thin course in mental deficiency or none at all.

The weakness of the court with respect to mental deficiency is essentially a problem for law and social-work schools. Even at best the technique of diagnosis, prediction, and planning for the mentally deficient calls for skills that cannot be expected of either judge or probation officer. Only a clinical adjunct to the court or an outside psychological and psychiatric service to which the case may be referred can meet this need.

WORK LIFE

One hears so much about mentally deficient children and so little about mentally deficient adults that he might wonder if the cases evaporate when the young people reach the age of 21. This is in fact serious, for unless the adult life of the person is known the training of the child is planned in a vacuum. In fact two things have helped to obscure these cases. On the one hand some who were identified as mentally deficient in school because they could not do the work there find work later that is within their competence. They thus have "recovered" from their mental deficiency. Others get along at a marginal level because of the help of friends and kindly employers, especially farmers, and so are not heard of. A few remain in the state schools. This discussion of work life should be longer than any other section of this chapter, for it covers the whole adult life of most mentally deficient and relates to the varied conditions under which they live and work in a highly complex industrial society. But it must be short because the body of knowledge about it is so limited.

Society has made little special provision for the employment of the mentally deficient. Since jobs are seldom adjusted to a deficiency, the mentally deficient person must make the adjustment by shifting jobs until he finds one that is suited to him. The Federal Office of Vocational Rehabilitation, it is true, provides for training in order to prepare the mentally deficient for normal job categories and has published a special volume on the mentally deficient,[18] but this provision is rarely used. There is need to help personnel directors in industry discover an economically sound place for the mentally deficient employee. Some believe he can adjust to simple repetitive routines better than the normal individual. Finding suitable jobs is a task of the state employment services, although only a few are equipped to give this specific help to the handicapped.

It must not be forgotten that the need for supervision is one of the criteria of mental deficiency. The failure to provide it forces a person with this handicap to hobble when with guidance he might get along quite well. The responsibility for this supervision has never been clearly allocated. Is it a task of the social agency, the public health agency, the state agency concerned with state schools, or some other? The social worker is more experienced in giving this kind of help and will eventually provide help to the mentally deficient in old age. He would seem to be best suited for this function, but the social worker needs better preparation in this field than he now has. Some state schools conduct colonies for girls who work in the community in domestic service, and of course in these cases the school is responsible for supervision.

For some mentally deficient persons, sheltered workshops serve as a proving ground prior to entering a regular job. But sheltered workshops are all too rare. Others need such shelter permanently. Some who have not been successful in regular work return to the sheltered workshop to recuperate from failure and make a new start.

DEPENDENCY AND OLD AGE

It can hardly be expected that the mentally deficient will accumulate enough financial reserve to carry them through their old age. Those who administer public-assistance programs are coming to appreciate this as an increasing part of their work. The Federal Bureau of Public Assistance is especially conscious of this need through both its aid to the permanently and totally disabled and its old-age assistance. There is great need for more experimental work with the mentally deficient who are old and permanently disabled.

INTERAGENCY RELATIONS

It is evident from the foregoing that mental deficiency is a concern of many different agencies. But no serious effort has been made in Federal, state, or local governments to bring about joint planning and coordinate action. In the Federal government the main focus of interest is the Department of Health, Education and Welfare where public health, education, social security, vocational rehabilitation, and services to children are all administered. Even within that one department there is no over-all plan. Mental deficiency also involves the Department of Labor (regulation of the work of minors) and the Justice Department (juvenile delinquency). Every one of these Federal functions has its counterpart in the states, and most of them also in the local communities, all similarly uncoordinated. The fragmentation of this field contributes to its stagnation. As those professions that serve the mentally deficient progress, they eventually encounter technical, departmental, or professional boundaries at which further progress may be blocked. Interdisciplinary arrangements for collaboration would open new channels for growth.

SOCIAL IMPORT

The statistics on mental deficiency are not sufficiently comprehensive to reveal its full extent. The National Institute of Mental Health of the U.S. Public Health Service reports institutional cases only.[19] It indicates that in 1951 there were 121,777 mentally deficient persons on the books of public institutions; 9,219 were admitted for the first time, and of these one-fourth were severely deficient, three-eighths moderately deficient, and three-eighths mildly deficient. The costs of institutional care are unknown because the mentally deficient also constitute a large part of the population of institutions for the epileptic. The total maintenance cost in the United States for both groups in 1951 was nearly $92,000,000, and capital expenditures were over $14,000,000. This is the cost of a year's care of less than one-tenth of all the mentally deficient. Those who live in the community entail special costs due to repetition in school, juvenile delinquency, public assistance, and medical care. These are dollar costs. To them must be added the burdening of the family of the mentally deficient, the slowing up of the regular classroom by a child who is misplaced there, the strain on the teacher, and the loss of productivity. As against these losses there is the potential for good citizenship (within the bounds of limited intelligence) and for productivity with good training and supervision.

SCIENTIFIC STATUS

Considering the advances that have been made in the understanding and control of other human diseases and defects, the body of scientific knowledge about mental deficiency is deplorably small. Any other disease or defect of comparable seriousness and extent is the subject of intensive research. Not so with mental deficiency. Even if by some system of value these people are not worth salvaging, or not worth spending money and scientific effort on, then it would still be shortsighted to ignore the possibilities of understanding normal function better that would come from research on the mentally deficient. Unexpected gains have already come to education generally by psychological studies in this field. Of all the researches supported by the National Institute of Mental Health, very few have been concerned with the mentally deficient. In fact few requests have been presented for the support of sound projects. Many centers well situated to conduct research are in fact doing little, although some of these were at one time busy research centers.

As has been previously pointed out, very interesting studies were under way thirty years ago on the least promising of all the mentally deficient—the idiot. This research revealed that some of the idiot's characteristics are due to his isolation rather than to his lack of intelligence. In one of his early studies L. P. Clark[20] showed that providing the idiot with close and understanding and affectionate human relations reduced the effects of his isolation and improved his behavior. He pointed out that

> . . . between the two extremes of doing nothing for the mentally retarded and of hoping for a cure there would seem to lie an extensive field for research and conscientious endeavor. Can we understand more of the nature of mental ar-

rest? While still granting that the ultimate cause is probably an inherent defect, is it possible in amentia to see dynamic elements which are more closely connected with the phases of everyday functioning and adjustment?

Of course since mental deficiency is present in some 70 different diseases, research must be specific for each. It is impossible to generalize as to cause, treatment, or outlook. The study of mental deficiency involves biochemical and physiological, psychological, psychiatric, sociological, and anthropological research.

PERSONNEL

Every category of personnel in the field of mental deficiency is in seriously short supply. Furthermore, except for teachers, the various professional schools offer no specialized training for dealing with this group. Staff vacancies are filled by persons who happen to have had experience or by inexperienced persons who must build up their competence on the job. Medical schools give little attention to mental deficiency. Trainees in psychiatry get little experience, for most training is given in hospitals for the mentally ill. Massachusetts,[21] however, offers training that promises to correct this fault. Even the standard classification of mental disorders [22] includes only a reserved space for mental deficiency to be filled in later. Nurses, social workers, elementary teachers, recreation workers, and lawyers are poorly equipped, although they constantly deal with the mentally deficient. Even psychology, which has devoted the most attention to mental deficiency in the past, is tending to follow the example of psychiatry and turn its attention to other interests instead. As long as these problems are considered hopeless, there is little incentive for inspired people to train for service or research.

The professional association in this field is the American Association on Mental Deficiency. It began in 1876 as an association of medical superintendents of schools for the mentally deficient, but it wisely broadened its perspective to include other professions and even some lay members. It thus became one of the early multiprofessional bodies concerned with human problems. But since it is not buttressed by well-designed professional training and strong group identification, this organization suffers from an unusual high turnover of membership. The official journal of this organization, the *American Journal of Mental Deficiency,* is multiprofessional and is the chief vehicle for scientific reports on mental deficiency. Other national professional associations interested in mental deficiency include the American Psychiatric Association and the American Psychological Association. A special citizens' organization, the National Association for Retarded Children, gives special attention to this field and works closely with local associations of parents. In addition the National Association for Mental Health includes mental deficiency within its scope.

AUSPICES AND LINES OF AUTHORITY

The fragmentation of public service to the mentally deficient means that within a state there is no convergence of responsibility at the top at any one point below the governor. The state residential schools usually report to the same authority as the state mental hospitals, while the public schools report to the state departments of education. The preschool services, in so far as they exist, are apt to be identified with child health and the department of health. Regulation of work is limited to child labor provisions in the departments of labor. Public assistance is in a department of welfare which sometimes also administers institutions. The state university is the logical facility for the preparation of personnel and for the conduct of research. Except for a few states such as New York there is, as a rule, no coordinating authority. There is, in short, need for a thorough study of the administration of public services to the mentally deficient and planning so that the administrative structure will coincide with the functions to be performed.

One impelling reason for a closer coordination of state services to the mentally deficient is that many states have already established traveling psychiatric clinics. These clinics see many mentally deficient whose future depends upon some other state authority. It seems unnecessary, then, to plan for another network of clinics to specialize in this field. In fact in most cases the problems of mental deficiency and emotional disturbance should not be separated.

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10 THE LEGAL OFFENDER, THE POLICE, AND THE COURT

Many offenses are committed by persons with obscure deviations of personality which are moralistically labeled "badness" for want of a more penetrating name. Of course, some of these are patently the result of frank mental illness. The wording of laws for the commitment of the mentally ill person as "a danger to himself and others" shows that the public understands that some offenses are the result of mental disorder. The public also understands that certain crimes such as those of pyromaniacs do not make sense in terms of the usual criminal motives, but are instead the acts of queer people. But the public is reluctant to believe that badness can be brought about in the same way as madness by unfortunate life experiences. Even when it accepts this possibility it still is apt to consider it hopeless to try to change criminal tendencies in the adult, excepting by some nonscientific means such as divine intervention.

BADNESS OR MADNESS?

The public believes that badness constitutes a well-defined and valid classification in itself, apart from other behavior deviations. It believes that the bad are not caused to be bad; they are inherently evil. It resists the idea that they are people whom society has offended and who in turn cannot assume a rational and responsible position in society. Punishment is accordingly believed to be the proper reaction of society whether the punishment is reconstructive or deterring or not. By the same token, if toughness is accepted as the proper way of handling the offender, scientific methods of understanding and treating him will appear to be mollycoddling, condoning further transgressions and contributory to them.

Punishment rationally applied may have a deterrent or even an alterative effect, but it is generally merely retributive and applied apart from any rationale.

Since punishment is used unrationally, there certainly exists and there may be found within the punisher (i.e., society) some hidden or unconscious incentives toward this kind of reaction. For one thing, punishment draws a clear line between the "law-abiding" citizens and the offender. It differentiates his errors from theirs. Probation weakens that distinction, which most people cherish, and is therefore readily subjected to hidden oppositions. Does the normal person need this distinction because of his own susceptibility to breaching law and morals? Does it help him overcome this susceptibility to thus so clearly identify himself with the righteous? Undoubtedly a multiplicity of hidden forces are at work, but certain it is that the public generally finds it hard to believe that the offender is a sick person. The public, therefore, is more inclined toward retribution than treatment.

THE JUVENILE DELINQUENT

But this attitude is slowly changing. The study of the offender in the making, especially the juvenile delinquent, has begun to modify that view. In the latter part of the nineteenth century special provisions were made by some courts for handling juvenile offenders. It was felt that many of them could be salvaged while still plastic and while the causes of the delinquency were modifiable. Eventually in 1899 this belief brought forth the first separate juvenile court, in Chicago.

The Causes. Case studies showed that serious social problems preceded juvenile delinquency more often than could be the result of chance. They consisted of such conditions as disturbed family life, handicapped neighborhoods, and deficiencies of intelligence. These were believed to be the real Fagins and became the focus of treatment. But the fact that many children who are handicapped in these ways do not become antisocial suggested that hidden psychological forces were also at work. The juvenile court was not, however, at that time equipped to probe for these obscure causes. Consequently in 1909 psychiatric, psychological, and social services were made available to the Chicago court in the form of the pioneer child-guidance clinic developed there by Dr. William Healy and cooperating with community social agencies.

The Scientific Approach. The scientific attack on delinquency followed a general psychological assumption that behavior is caused by diverse constitutional, psychological, and social forces at work in the life of the person. These forces make him what he is. This genetic-dynamic approach contrasts with the demoniacal approach which identified the problem mystically with badness. These forces furthermore are not uniform but are combined differently in each case, a fact which contrasts with the common tendency to seek for simple cure-alls, even where a scientific approach is used. The misleading thing is that most of these cure-alls are cure-somes. While they work well with some cases, they help others only a little, and they fail with most.

With many children delinquency is an attempt to solve life problems. It is their way of dealing with such adverse conditions as bad housing; racial or other discrimination; inadequate reconciliation of cultures; inadequate adjustment of the school to the child; repressive, unloving, neglected family life; and a home or neighborhood atmosphere of vice and crime. Delinquency is the child's attempt at solution. It is not a good solution, but neither has society offered him a better solution.

Most people attempt to deal with these inequities with some degree of perspective and with the advantages of education, money, security, etc. The child attempts to deal with them just as earnestly, but without experience, without security, and without aids. Sometimes his fumbling hits upon a good solution, and it works. As a result, we have coming out of bad situations some remarkably successful people of high integrity. The effort of the child to balance these inequities is laudable. When he fails it is regrettable, but the tendency of society has been to penalize him for his failure, while at the same time it tolerates or makes a profit on the inequities that bear him down. This form of delinquency is not essentially symptomatic of disturbed mental health, although it may lead to mental ill-health. It is more of the nature of a *faux pas* which everyone would commit if forced to "do as the Romans do" without knowing exactly what the Romans do. It is, therefore, not treatable by individual psychotherapy, although the juvenile may be given help in finding better solutions for the inequities than the ones he has arrived at.

Sometimes the problem is essentially psychopathological in that the inability to deal with life problems may be due more to emotional disorder than to the pervading inequities. For that reason children of privileged families and neighborhoods also become delinquent. In any case the discrepancy between the child and the situation in which he lives cannot go on for long without impairing his mental health. There comes a time when one has not only to help the child solve his social problems, but also to solve the psychological problems such as resentment, hostility, and fear that grow out of his conflict with the world about him. It is at that point that the professions which are concerned with distorted behavior are drawn into action. But the efforts of the psychologist, psychiatrist, and social worker are not apt to succeed unless the child is also relieved of the social inequities that contributed to his deviation.

There is a common misbelief that if the social problems which induced delinquency are corrected the delinquency should forthwith disappear. But even with social acceptance, consistent affection, stable family life, and a school adjusted to the child's special limitations and talents, delinquency should not be expected to fade quickly. The child who has acquired habitual ways of meeting life, delinquency, is suffering not merely from a social deficiency disease, which would be correctable by removing the deficiency. The social deficiency has established fixed patterns of behavior. He is using the only ways he knows of behaving toward the world. To expect different behavior from him when conditions are improved is almost like expecting him to be able to speak another language. He is, therefore, often a great disappointment to those who are trying to help him because he does not give up his delinquency when its causes have been removed. A child who has calloused himself against an unfriendly world does not know how to deal with a friendly world. He can give up his defenses only very gradually.

This is the crux of many failures, for his continuance of delinquency in the face of friendliness and every effort to help often leads to a conclusion that the child is thoroughly bad. As a result he is rejected. This he understands. He has dealt with rejection before and for it he has ready-made behavior—antisocial behavior. This rejection raises still higher the defenses which he has found useful in the past.

It must be kept in mind that the delinquent is one who has been hurt many times. He has very limited sources of satisfaction in life. He is always on the alert for more hurt or for further deprivation. He will, therefore, react more violently to things that block him than will the normal child. He cannot be a trusting person, so he must be hostile. His hostility in fact has often saved him, even if it has also got him into trouble. He is so alert to what is going on now that he cannot be diverted to look far ahead. To defer satisfactions is to risk losing them, so he does not defer them. These are his defenses, and they interfere with efforts to help him. They are not easy to deal with.

THE ADULT DELINQUENT

As years pass and adulthood is reached, neglected delinquency becomes a more and more fixed way of meeting life. But with the adult and habitual offender the causes are often beyond reach; the parents' influence has passed, the neighborhood has changed, and the school is a memory. The only prospect of treatment now lies in a psychological attack on the established delinquent pattern.

Psychological Limitations. The term pattern is an apt one to describe the offender's behavior for he is narrowly molded. He is not free to choose and design his offense in keeping with opportunities. He is tightly bound by his pattern. He cannot be a burglar one day, a forger the next, and then a panderer. He tends to be a slave to his form of offense. This is often his undoing, for his type of behavior becomes known and narrows down the list of suspects in the event of an offense. Each chronic offender has his choice offenses and his choice ways of committing them. This is a sign of his mental constriction. With more pathological cases the crime itself is often the climax of a period of great tension, and the offender often gets a considerable feeling of calm after committing it. Arsonists show this dramatically. In some cases the failure of a criminal to cover his tracks is unconsciously intentional. He gets a feeling of relief when he is caught. He says, "I'm glad it's over." Extreme aggression and hostility are common among criminals. These psychological forces are not entirely spontaneous, but they do erupt with less provocation than would be expected.

Early criminologists tried to discover anatomical signs of degeneration in the criminal. Physical abnormalities of all sorts were described, but they explained nothing and hence offered no hope for treatment. Healy sought for psychological stigmata—habits of thinking, feeling, and acting which get people into trouble. Since those had presumably been caused by life experiences, they could possibly be removed by treatment or prevented by eliminating the causes. While he worked with children, his findings helped also to understand the adult case, for the progression from juvenile delinquency to adult crime was well recognized. It was because crime can be understood better in the light of mental disorder that the National Committee for Mental Hygiene early in its existence conducted psychiatric and psychological studies of the inmates in jails. It hoped to clarify the factors that were obstructing the scientific attack upon crime.

INSANITY AS A DEFENSE

The connection between mental disorder and crime is, of course, as old as the defense of insanity in criminal cases. Sometimes the mental disorder in these cases is obvious, but then the prosecution is likely to accept the defense of insanity as reasonable. It is, therefore, generally accepted that serious offensive acts are not always criminal even when superficially the behavior is the same and the results are the same, e.g., homicide. It is agreed that some people are so deviant mentally that they are not to be considered accountable, whereas others are so well preserved as to be considered capable of committing a crime. Intermediate cases call for psychiatric opinion to clarify the degree of deviation. Psychiatric judgment is especially needed in borderline cases, and it is just there that a difference of opinion in a court among the experts is likely to emerge.

The struggle to find a way of arriving at a clearer definition of what is or is not insanity in criminal cases resulted over a century ago in some definite rules—the so-called M'Naghten rules. These rules call for a decision as to whether the defendant knew the difference between right and wrong and the nature and quality of his act. They, however, grew out of legal rather than psychiatric thinking and practice. They call for judgments that are foreign to clinical work. As a result these rules lead to a factitious conclusion. Often the expert makes up his mind that the defendant is mentally ill or not by using the customary examination and then on the witness stand offers his conclusion as if it were arrived at through these rules. In 1954 the validity of the M'Naghten rules was reviewed by the United States Court of Appeals for the District of Columbia[1] with the conclusion that both the right-wrong test and another, the test of irresistible impulse, are inadequate.

Efforts have been made to avoid the "battle of experts" in such cases, one solution being the provision of a nonpartisan report by a panel of psychiatrists for the court rather than for either adversary, with provision for examination of these witnesses by either side. The Briggs law of Massachusetts was a notable step forward in providing unbiased psychiatric testimony on criminal cases through the provision of official psychiatric services. One result of the concern for the criminal who may be insane is that it has forced a more careful study of the borderline case. It has also brought about a better understanding that the criminal himself, as well as his prey, is the victim of his psychological deviations.

SPECIAL TYPES

It is common for the offender to be labeled psychiatrically as a case of psychopathic personality, a type of disorder not ordinarily classified as insanity. In general this category includes persons, usually of normal intelligence, who are not obviously mentally ill. Cleckley portrays them as having only the mask of sanity.[2] They are persons of extreme irresponsibility who take what they want without guilt, anxiety, or compunction as to the culture or the rights of others. There is much disagreement as to the validity of this category as a diagnosis. Many persons who have suffered brain injuries show these same tendencies, while on the other hand many cases seem to be more closely akin to the neuroses.

Many sex offenders are put in this class, but sex offenses appear also in the behavior of persons with other forms of mental illness such as schizophrenia and senile dementia. Some persons express themselves sexually in unusual ways and are offensive to society because they do harm. But many sexual perverts are more repulsive than dangerous, and some rapists are really not violent but are rather sexually promiscuous men whose chief crime is that they were involved with girls who were younger than the statutory age of consent. Psychiatry can at present offer little promise of reforming sex offenders. Nevertheless, carefully recorded psychiatric study and treatment should be provided as the only hope of making scientific progress.

Of special interest in this regard is a report by the Group for the Advancement of Psychiatry.[3] Some popular misconceptions of sex offenders are discussed in the report of the Council of State Governments.[4] This report points out that they are not lurking everywhere and that they are not consistently oversexed. Most of them are not repeated offenders. They tend to stick to their favorite offense, they are not insane, and they cannot be controlled merely by passing laws. A study in California[5] showed that only about 20% of the sexually promiscuous have an abnormally high sexual appetite. Their promiscuity is rather a casting about

—unsuccessfully, to be sure—for a warm human relationship that was denied them in their earlier lives. In a conclusion that bears upon all offenders another study points out that "both legal thought and public policy are departing from . . . specific punishment for specific crimes. . . . Increasing attention is being centered on the offender, his inner motivations and his rehabilitation. The problem of prevention [of sexual offenses] merges into the broader field of mental hygiene."[6]

The defective delinquent constitutes another category of mentally disordered offenders. These cases of mental deficiency are usually committed to a penal institution, but that is not the place for them. It is not suited to their shortcomings, and they constitute a special problem for the staff. On the other hand, the institution for the mentally deficient allows too much freedom for one of criminal tendencies. New York has made special institutional provision for these offenders, but most states neglect them. Regional planning may help several states provide suitable facilities in common.

The criminal insane have already been referred to. These cases also are not suited for either prison or state mental hospitals. Most states provide special prisons or wards in state hospitals for this group, but here also regional planning may lead to a better solution. These facilities care also for the accused whose mental illness precludes his standing trial and for the criminal whose mental illness is unrelated to his offense.

SOCIAL INSTITUTIONS AND THE OFFENDER

To get a full perspective on the social institutions which deal with the offender one does not begin with the police. Many other agencies in the community know of offenders as such long before police action is taken. These agencies include all that bear on mental health—doctors, health officials, schools, social and recreational agencies, and churches. But the agencies that are specifically identified with the offender are the police, the court, the probation services, and the correctional institutions. Serious mental deviates are found on the rolls of all these agencies.

Institutional Deficiencies. In general the approach of the correctional institution is punitive. At best it takes the criminal from society for a while, but it rarely treats him for his problem. Neither the concept of his problem nor the process employed in dealing with him is scientifically founded. The process of incarceration is not studied to discover its impact upon him and its influence in realizing the objective of correction. Some criminologists claim that the process to which criminals are subjected in general makes them worse rather than better. Some prisons have "samples" of progressive work, but these are applied to only a small portion of their inmates. They have hospitals, psychiatric clinics, education, industry, and entertainment in token form, but these are seldom set in a total framework that is conducive to recovery.

Administration of the correctional institution is influenced strongly by the tendency to make administration as easy as possible. Often the purported aim of alleviating the criminal tendency is secondary. In spite of subjecting an inmate to long and restrictive incarceration, depriving him of those day-to-day experiences upon which normal people depend for their mental health and satisfactory adjustment in the community, penal institutions provide little preparation for release. They provide schools and churches, but they disregard the fact that the inmate's motive for attending them is most often to bolster his record in anticipation of parole. The institutions have not enough psychiatric and psychological staff to meet the needs of the mentally ill. The annual reports of the penal institutions in some of the more privileged states show how little is done for the mental disorders among the inmates. One such state devotes not one word to this service, while it devotes eight lines to the soapmaking department.

PRISONS

Penal institutions have approximately 10% of inmates with psychoses. Between these and the single-offense case there are those who are chronically more or less mentally sick but not psychotic. These were sick before the crime and are still sick after discharge. Unless there is good classification the needs of these mentally ill are often not even sensed.

In general the Federal prisons have dealt with the mental health problems of the offender much more wisely than have the state services. The establishment of the Bureau of Prisons in 1930 provided enlightened central leadership for these institutions. It was the intent of Congress to "assure the proper classification and segregation of Federal prisoners according to their character, the nature of the crime they have committed, their mental condition and such other factors as should be taken into consideration in providing an individualized system of discipline, care and treatment of the persons committed to such institutions."[7] In keeping with this mandate the Bureau has constructed penitentiaries, reformatories, institutions for youthful offenders, and correctional schools. It has special facilities for the chronically ill and mental cases. These institutions are supplied with psychiatric service through the U.S. Public Health Service, but the number of personnel is insufficient to meet the heavy demands made upon them. In addition to giving direct psychiatric service to the prisoner, the psychiatrist has to participate in classification, discipline, and parole and in the training of nonmedical personnel. The Federal prisons have a strong psychological service, but this is likewise overburdened by the many functions that must be performed in addition to classification. In spite of their limitations the mental health resources of Federal prisons rate so well that their support is a duty of every citizen as a pattern for the states to follow.

TRAINING SCHOOLS

Training schools for delinquent boys and girls vary widely. Some schools are content to be kind, to meet the child's material needs, and to provide the community with a respite from his annoyances. Other schools aim to study each child and plan for him according to his particular psychological needs. They have good psychologists, social workers, psychiatrists, and teachers. They select their cottage personnel carefully and train them to participate in the reconstructive effort. But they lack sufficient personnel to fully realize this ambition. All these schools are handicapped by the fact that their charges are not a part of the community whose deficiencies helped to create them, and there is no continuous effort to overcome the deficiencies of the child's home town during his absence from it. His adjustment and progress within the school do not therefore provide an adequate test of how he will behave when he returns home. These schools suffer from the same disadvantages of isolation that beset the state hospital. They belong to hundreds of communities, and hence to none. They cannot assume the responsibility for house cleaning to rid all those communities of their noxious influences. Still they have the concentrated evidence of these noxae. These neglected and offended children tell more about community defects than those who do not get into serious trouble.

There is grim truth in the quip that in the course of their training for crime children graduate from public school as chronic truants, go on to secondary education in the state schools for delinquents, enter junior college in the reformatory, and finally complete their higher education in the prison. They return again and again to the prison to serve as faculty for new students. The less obtrusively disturbed child is more likely to follow this sequence than the severely disturbed or psychotic child, because with the latter disintegration may be so serious as to preclude a "successful" career in crime.

PREVENTION

The function of preventing delinquency is properly claimed by many agencies in view of the diversity of causes of this problem. Child-guidance clinics began with a specific focus on the delinquent, and their aim was later refocused on the prevention of delinquency. It soon became evident, however, that they prevent delinquency best by operating closely with other agencies besides the courts. The community-services grants of the National Institute of Mental Health have greatly expanded clinic services and played an important part in the effort to control delinquency.

There are two other social institutions which are specifically concerned with offenders but which even more are in a position to sense and deal with their problems and their causes. These are the police and the court.

THE POLICE

The police could be a line of defense against delinquency instead of merely a line of defense against the delinquent. Their very being is dependent on the fact that people behave themselves badly, offend others, and need to be regulated. Yet they have little or no preparation to understand the causes of misbehavior or to differentiate between its different forms, e.g., misbehavior due to an excess of insulin or alcohol. Alcoholism is the police officer's daily concern, and more serious offenses, assaults, rapes, and other sex offenses also involve a large amount of mental disorder. Even traffic violations are to a considerable degree caused by mental ill-health. A log of the hour-by-hour activities of a policeman demonstrates the extent to which his day is occupied with various forms of mental deviation. Police are usually not prepared beyond the resources of common sense to identify misbehavior in the making. They are, of course, limited by the Bill of Rights in their freedom to arrest the potential offender. But they can do much without invading civil rights. Many police individually do magnificent work in prevention and early treatment. They identify the signs of mental deviation and know how to render first aid.

Some know intuitively how to work on an informal basis without using authority. But their efforts are gratuitous. Police science and training of police officers are not so planned as to prepare all others to do likewise. This is an expensive omission for society. It is another instance of the force of administrative ease as a deterrent to progress in our social institutions. Easy administration rejects new responsibilities when things are running tolerably as they are. For that reason it has been difficult to convince police officials—with some notable exceptions—that the training of police should prepare them to sense mental deviation and to render first aid. The police commissioner in one large city rejected a free offer of personnel to make a study of the mental health problems encountered in the day's work of a police officer because he feared it might lead to additions to the crowded training course.

Every police officer should know enough of the following peculiarities of behavior to question whether a person may be mentally ill: sudden change of behavior; unconsciousness; confusion; loss of memory; hallucinations, hearing imaginary voices or seeing imaginary objects; delusions, i.e., false interpretation of circumstances; suspicions of enemies, belief that he is being watched and talked about; suicidal attempt; strange complaints of bodily disorders. Then he should know how to bring the person in touch with careful psychiatric examination and diagnosis.

THE COURT

The establishment of a juvenile court, separate from the criminal court, did not imply that adult offenders might not also benefit by careful social, psychological, and psychiatric study. The juvenile court merely served as a more hopeful starting point, capable of enlisting public sympathy. The juvenile court has already had a salutary impact on criminal courts. Social and personal investigations, both pretrial and presentence, are not at all uncommon today. Still they should be greatly improved and expanded. In some states the juvenile court has been taken entirely out of the criminal category, so that its judgments are of the same nature as findings of neglect. It is more a judgment of failure of the family or community than a finding of guilt against the child. But even where this is a purported theory a lagging court may still act like a criminal court. On the other hand some courts are more enlightened than the antiquated theory under which they operate. The need for psychological understanding by the court is general and not limited to its criminal actions.

In addition to dealing with offenders the court adjudicates other problems which involve mental disorder. It commits patients to mental hospitals. It handles domestic-relations problems, problems of dependent children, and habeas corpus proceedings. The court may adjust its procedure to such deviations or follow a formality that ignores them completely and thereby risk aggravating them. The mental problems are especially apt to be aggravated through the adversary procedure which obtains in divorce cases, where emotional disturbance is usually basic to the problem.

In 1940 the American Law Institute developed two model acts similarly conceived for the handling of youthful offenders. Unfortunately the proposed "Youth Correction Authority" would deprive the court of its constructive function of probation. Consequently no state has adopted it. A few states[8] have, however, established youth authorities which have included probation within the court. The National Probation and Parole Association[9] has subsequently drafted model acts for probation systems.

An important factor in retarding progress in the juvenile court in the United States is that the judgeships are seldom a life career. They are mere steppingstones in professional or political advancement. The juvenile-court judge begins with few skills for dealing with mental deviation. He may develop them well in the job, only to leave the task to a similarly unprepared successor.

The backbone of many courts is its probation officer, especially if he is a well-trained social worker. The probation officer is a career person and lends continuity to the court's work. He helps the court to understand the mental make-up of the offender and serves as an arm of the court whereby the conditions which helped to produce the offender in the beginning and to which he may return are modified in behalf of his successful adjustment. If the court does not have psychological and psychiatric facilities of its own, the probation officer draws upon those of the community. He helps to replace a punitive approach to the case with reconstruction.

England has brought about longer tenure for judgeships by appointing as magistrates volunteers who make this a lifetime career. While these magistrates are not lawyers, they have lawyers available to them. Many of them accumulate great wisdom and understanding in the course of their careers.

Most communities have quite inadequate detention homes for children pending court action. Some courts are so overburdened that children may be held for months before adjudication is completed. Certainly jails should not be used for this purpose. Boarding homes are more suitable, but their value depends upon the attitude of the adults who conduct them. The principles of good detention are detailed in a report[10] issued by the National Probation and Parole Association.

ESSENTIALS OF PROGRESS

The problem of the offender is from beginning to end a problem of mental deviation. Therefore the mental health tasks of those who deal with the offender cannot be realized without psychological understanding and treatment of the offender himself. A therapeutic principle needs to replace the custodial or retributive principle in the correctional institution, the court, probation and parole facilities, the laws, the police, and—basic in all—the public itself. No one has adequately assessed the cost of implementing this principle. An adequate service is costly, but it is also costly to suffer the depredations of the offender. It is costly to try to rehabilitate him, it is costly to lose his productive capacity, and makeshift measures merely allow basic causes to persist. The offender reminds us by his very existence that society has bungled by failing to make the community a good place in which to grow up. This bungling handicaps not only the offender but a large part of the remaining population. It is most costly.

Are delinquency and crime increasing? The statistics would seem to say that they are. A 1954 report of the Senate Sub-Committee to Investigate Juvenile Delinquency found an increase in juvenile court cases of nearly 30% in four years (1948 to 1952), but the procedures of case finding, formal or informal handling by the court, and the use of other agencies than the court to handle cases make these statistics very hard to interpret. Over two million crimes were reported to the Federal Bureau of Investigation in 1952, and of these about 25% resulted in arrests. The percentage of arrests is, however, higher in the case of more serious offenses. Better statistics are needed.

Scientific criminology has great need for more and more research. There is no good evidence that punitive methods are effective. There is better evidence that the therapeutic and sociological approach is more effective if applied early. Early treatment does not start with the first recorded offense. The histories of first offenders show that they have been mentally and socially disturbed long before the offense and that they are social problems in other ways than through crime.

The scientific status of this field can be summed up in a few words. Too few scientists are at work on it. Those who are at work are given too little support, and at present society is not using all that science has already revealed. Efforts to treat and prevent delinquency are timid and stingy. They follow the easy way. They strike at single causes rather than the conspiracy of many factors that lies behind most cases. The forces that play a role in the production of crime also cause other forms of deviation, so that scientific research and treatment should not be directed toward the treatment or prevention of offenders alone, but toward the broader psychological problems which underlie delinquency. It is more than coincidence that emotional problems underlie reading disabilities in school and that reading disability is common among offenders. The paucity of special and individualized education in the schools leaves the child vulnerable. A report [11] issued by the Children's Bureau of the U.S. Department of Health, Education and Welfare lists the following program for the treatment and prevention of delinquency: (1) more special training for police; (2) proper detention facilities; (3) more and better-trained probation officers; (4) better equipment and staff for training schools; (5) coordination of state and local agencies for children; and (6) extension of mental hygiene services.

Many general psychological and sociological discoveries are applicable to criminology because the field is so broad. Especially significant, however, because it is identified with delinquency and at the same time sternly scientific, is the work of the Gluecks.[12] They have burrowed among the many variables that are associated with delinquency and have come up with a small number which are consistent enough to be used in prediction.[13]

It has already been pointed out that the public is prone to look for easy and cheap answers to the treatment and prevention of delinquency. Solomon [14] challenges each of these easy answers: sports, recreation, youth serving agencies, curfews, work with teen-agers, clinics, avoidance of the formality of arrest, and the substitution of other agencies for the court. The elimination of slums, divorce, and comics is also considered. Each of these "solutions" has its defenders. Solomon points out how these nostrums fail to deal with the complexity of causes. He challenges those who feel that they can get off by paying a token price for prevention instead of the full cost. He advises instead the provision of aids to strengthen the vulnerable case. This calls for a continuous assessment of the mental strength of the child; a search for the causes in each case in the home, the neighborhood, the school, or the culture; and the mobilization of many agencies of the community. The Chicago neighborhood project growing out of the classical studies by Shaw of deteriorated neighborhoods recognizes the complexity of causation of delinquency and tries to bring about an improvement of the total neighborhood. It uses the inner resources of the neighborhood rather than leadership and facilities introduced from the outside.

While services to the offender constitute quite distinct social institutions, with a distinct clientele and distinct technical obligations, there is no such distinct professional preparation for the field. Those who are active professionally come from a variety of professional fields. Physicians, psychologists, lawyers, clergymen, teachers, and others attempt to deal with offenders without special preparation.

Psychiatric education at present is, as a rule, very narrowly concerned with gross mental illness. There is need to expand this education to include work with the offender. The same is true of the other professions. But even when competent psychological and psychiatric staff is available in a correctional institution, the treatment of the offender often is not within their discretion. It usually has to be approved by a higher administrative authority who is not competent to make a clinical judgment. The large number of cases and the multiplicity of duties imposed on the staff seriously reduce the effectiveness of even highly skilled personnel. Such a job is too discouraging to attract or hold personnel of high quality. Were the duties of a psychiatrist or psychologist limited to the examination of prisoners, four or five cases a day would be enough. When in addition he is called upon to attend disciplinary proceedings (warden's court), provide outpatient service, provide opinions for parole boards, deal with correspondence with relatives and with other institutions, and perhaps make special reports to higher authorities such as the governor, good professional work is impossible.

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11 THE COUNTY HOME AND MENTAL HEALTH OF THE AGED

The term *county home* is used to identify a certain class of institutions which in general serve as homes for persons who are economically dependent. These institutions vary greatly in their structure, purposes, clientele, auspices, types of organization, and staffing. In general the county home is the descendant, and sometimes a very refined descendant, of the old almshouse. The state hospitals have taken over a part of the function of the almshouse in most states, public assistance in the community has more or less taken over another part, but there is a residual group of needy people whom the county home serves.

CLIENTELE

The residents of these homes are often chronically ill, but medicine has nothing more to offer them for their chronic illness. Many of the patients are senile and suffer the inroads of brain damage which eventually results in senile dementia. But these and other mental cases are either not aggravated enough or treatment is not promising enough to warrant their placement in a mental hospital. An analysis of the composition of residents of county homes by Ginsberg and Brinegar [1] showed that these homes have four classes of inmates: the poor, the general medical case, the alcoholic, and the psychotic. They estimated that there are 60,000 such inmates in the United States over 65 years of age and that 30,000 of these are psychotic. Psychiatric patients are considered hopeless and given little treatment. The result is low-cost custody. In general these homes are not administered as hospitals.

SUPPORT AND ORGANIZATION

The distinction between the function of the county home and that of the state hospital becomes less as one studies the needs of the mentally ill inmates. A hospital or a home for the aged and chronically ill is faced with mental hygiene problems even with its nonpsychiatric case. It must protect the patient against psychological disturbances, not only because emotional turmoil is distressing but also because it aggravates cerebral, cardiac, and kidney disorders. Especially is it necessary to be on the alert for paranoid tendencies, since psychiatric symptoms are often the first warning of organic diseases. Those who are devoted to the treatment of old persons are convinced of the value of psychotherapy.[2] Serious bodily disorders may in fact be forestalled by alleviating the emotional disturbance. Too often the behavior of older people is explained in terms of the aging process. It is forgotten that like others old people behave according to patterns which they acquired early in life. If as children they were unsure of their parents' affection, now when they are again weak and dependent the childish ways of winning approval may crop up. For that reason psychiatric service may be a lifesaver in the county home.

Of course, a clear distinction between the functions of the state hospital and the county home is impossible, since the problems with which they deal constitute a continuum and cannot be distinctly classified. The most disturbed senile patient in such a home will always be found to be more disturbed than the mildest case in a state hospital. Consequently it is imperative that these institutions work in close cooperation. The county home should not become a mere outlet for the static case in the state hospital. It has a more active mental health task.

A 1950 amendment to the Federal Social Security Act provides grants to states having satisfactory institutional plans for the totally and permanently disabled. This category includes those who are mentally as well as physically handicapped. The definition of permanent and total disability is left to the states, which in turn are quite liberal in their criteria of eligibility. The original Social Security Act of 1935 makes similar provision for persons aged 65 or older. In 1952 national, state, and local governments spent over $100,000,000 for the permanently and totally disabled, even though some states were not yet included. They also spent over $1,600,000,000 for old-age assistance. Of course, many small or rural communities have not the facilities to take advantage of Federal provision for the permanently disabled. For that reason the Eighty-third Congress decided to extend the general hospital-construction law to assist with construction for this purpose.

Isolation is a serious hazard to the county home. To overcome this it needs close working relations with the other mental health agencies. It needs enough medical service to identify and treat its psychiatric patients. It needs arrangements for quick transfer of patients to a psychiatric hospital. It can benefit by affiliation with nearby medical centers. It needs volunteers. A small percentage of the patients in county homes will return to community life. To facilitate this, as well as to brighten the patient's life, a close relation between the patient and his family (if it is a happy relationship) needs to be preserved. To these ends good social service is required.

MENTAL HEALTH OF THE AGED

The mental health of the aged in county homes is but a small, even if dramatic, portion of the concern for the mental health of the aged in the community. There are some twelve million residents of the United States over 65 years of age. Many are psychologically so fragile that serious damage may easily be done to their mental health. However, they can be strengthened psychologically by control of the atmosphere in which they live. Suggestions for community action in behalf of the mental health of the elderly have been published by the author.[3] Quite apart from the bodily changes attending old age which lower mental efficiency, the social situation demands many readjustments. Old people do not make readjustments easily, either because of fixed habits or because they feel that they are too near the end to justify the effort to change. The need for these readjustments is occasioned by dispersion of the family, widowing, decreased financial resources, and forced retirement.

Especially can forced retirement for a person who has no creative and satisfying avocation be devastating. The fixed forced-retirement age deprives many who have a high creative and productive potential of the opportunity to realize it. Forced retirement comes about because younger persons are pressing their seniors to retire so as to open up opportunities for jobs for advancement in rank and for seniority. In addition the employer likes standard-age retirement because it spares him the embarrassment of confronting some older employees with the rugged truth about their decline. As a result of these pressures, employment declines rapidly after 65 in nonagricultural work.[4] Before that age 90% are employed; from 65 to 69, only 60%; from 70 to 74, about 40%; and after 75, 20%. The greatest psychological threat of retirement is dependency. In addition social uselessness carries the threat of becoming a nobody. Idleness then becomes a serious mental health problem, for the emotional disturbances which accompany enforced idleness often contribute to the senile mental breakdown.

The physician and the clergyman are most strategically situated to do something about the mental health of the aged. But many other agencies of the community are also able to contribute to their stability. The great need is that community mental health services to the aged not be left to chance, that there be a plan whereby each agency knows its role and its relation to the others.

NOTES

1. Ginsberg, Raphael, and Willard C. Brinegar: "Psychiatric Problems in Elderly Residents of County Homes," *American Journal of Psychiatry,* 100(6):454–459, December, 1953.
2. Turner, Helen, and A. I. Goldfarb: "Psychotherapy of Aged Persons: Part II, Utilization and Effectiveness of Brief Therapy," *American Journal of Psychiatry,* 109:916–921, June, 1953.
3. Stevenson, G. S.: "A Guide to a Community Committee on the Mental Health of the Aged," *Mental Hygiene,* 37:265–277, April, 1953.
4. *Statistical Bulletin,* Metropolitan Life Insurance Company, New York, 35(2):1–4, February, 1954.

12 THE HALFWAY HOUSE

When patients leave a mental hospital they are classified as recovered, improved, or unimproved. Most of these patients have made a satisfactory adjustment within the hospital and have received whatever treatment the hospital has to offer. But recovery and adjustment within a hospital do not mean that the patient can resume a normal life in the community. He must be protected from the pressures of life which have contributed to his illness.

There are some 85,000 patients on the books of mental hospitals who actually are in the community. Of these, 60,000 are discharged each year, and 125,000 in addition will be discharged (removed from the books) directly from the hospitals, for the most part to return to normal life. Many patients are readmitted to the hospital because they have not had help in the community. This is a human loss of serious proportions, to say nothing of the added tax burden.

THE THREAT OF RECOVERY

Fear of returning home to old responsibilities may halt the full recovery of a patient who has been making good progress. Figuratively he lingers on the threshold of the hospital, and if the staff is overburdened with work they do not see him standing there or give him the personal support that he needs at that point. Also the patient is too unsure of the future to ask for this help. Surveys of mental hospitals therefore reveal many patients who could be helped over the threshold.

Most patients who leave the hospital as recovered are still therefore convalescent. They are not ready to return in full force to the normal stream of community life, but they will return more fully and successfully if they are given help from the community. Those who are merely improved need this help still more. But this protection is seductive. The patient can become too dependent on it, and it may then block his full rehabilitation.

The patient's apprehension about returning to the community is really more rational than the community's attitude toward him. He knows that he must face suspicion and stigma, social discrimination and occupational prejudice. While he is no longer ill, he still has a social problem. To deal with this problem is most logically the concern of those who have helped him to recover. They can sense his predicament and help him because they know him best. They can also help the community to understand his needs. But very few hospitals and clinics really give this help and leadership. In fact social rehabilitation is not today a serious part of the training of personnel or a serious subject of research. Hospitals have, of course, developed social service and outpatient clinics. These outpatient agencies sometimes maintain a close and helpful relation with the patient while he is readjusting to the community and notify the hospital in the case of need. But the amount of clinic service and social-service staff is a mere token compared with what is needed.

SOCIAL REHABILITATION

However, apart from assistance that is rendered by the hospital and the usual health and welfare agencies of the community, there are in all states vocational and sometimes also social rehabilitation agencies specifically set up to bridge the gaps between sickness and health. Vocational rehabilitation will be dealt with in another chapter. Agencies that help the patient back into a normal social relationship in the community are often called *halfway houses*. Such agencies are scarce, and those which exist are either designedly or blindly experimental. Some of them not only serve the patient who has left the hospital but also provide a social refuge for some who find the community too complex. There they regain perspective, composure, and courage without going to the hospital. Fountain House,[1] in the heart of New York City, and Spring Lake Ranch,[2] in rural Vermont, are examples of these types. Both these are private agencies. Private psychiatrists refer most of the members of the latter, and many of its members have never been hospitalized. Fountain House, on the other hand, serves former patients of mental hospitals. There is no well-developed scientific body of knowledge and tested experience in this field. Consequently the few halfway houses that exist should be planned as experiments as well as to provide services.

The halfway house is a nonmedical agency. Reik [3] has pointed to the special significance of its nonmedical atmosphere and its nonmedical staff in that it tries to maintain an atmosphere of health rather than illness. For that reason its beneficiaries are called members rather than patients and must be selected carefully so that they do not need to be treated as patients. The purpose of the halfway house is more like that of the school or recreation agency, i.e., to develop and strengthen normal capacities. It, of course, also shelters its members, but it differs from the sheltered workshop in that the purpose is not vocational but social.

A halfway house feeds responsibility gradually to its members, including responsibility for the operation of the house. This responsibility is measured so as not to exceed what the member can carry with fair promise of success. At the same time these protections and the satisfactions that go with them are not permitted to interfere with the member's interest in leaving the center at the earliest possible time and entering into the social life of the community. The sign of success in such a center is the rapidity of turnover of its members. The more successful it is, the shorter will be their connection with the center as recipients of its help. Consequently members cannot provide enduring leadership and responsibility within the center. The goal is to get the member back in the normal stream of community life as soon as possible and look upon him as recovered.

While the halfway house is nonmedical, it must work closely with the physician who is concerned with the member. The halfway house is in a good position to discover its members' needs for mental attention and the conditions in the community which retard their progress. It needs psychiatric advice to guide it in dealing with disturbed members and to help determine the readiness of a patient to use its services. Local agencies that collaborate with the mental hospital in the treatment of the patient need also to work closely with the halfway house. These include particularly the agencies concerned with the family, vocational rehabilitation, employment, and public health nursing.

A distinction needs to be made between the halfway house and the organized group of patients who try to help each other or who are helped by a psychiatrist through group therapy. Recovery, Inc.,[4] is probably the best known of these patients' groups.

Halfway houses should not begin their work with the hardest cases. They can more readily clarify their techniques and strengthen their positions in the community if they start with recovered patients who need only a brief period of socialization. Later they may take a few members who will remain a long time and never return to normal community life, but who may be spared readmission to the hospital. There is also a temptation for the halfway house to assume services for which vocational and medical agencies are designed. This practice not only complicates the work of the halfway house but removes a pressure on these other agencies to fill their roles more completely. The halfway house does better to make these deficiencies known to those who can remedy them than to try to fill the gap itself.

NOTES

1. Fountain House, 412 West 47th Street, New York.
2. Spring Lake Ranch, Cuttingsville, Vt.
3. Reik, Louis E.: "The Half Way House," *Mental Hygiene* 37:615–618, October, 1953.
4. Recovery, Inc., 116 South Michigan Avenue, Chicago.

13 OUTPATIENT SERVICES AND RESIDENTIAL CARE OF MENTALLY ILL CHILDREN

The physicians of mental hospitals have probably always provided informal outpatient service, giving it as the need arose, and many still do this. However, outpatient psychiatry proved thereby to be of such value that many hospitals began to put it on a more formal basis. A member of the staff of a hospital would spend a set day in an important community in his district, examining and treating patients. Some may have been former patients of the hospital in whom the serious-minded doctor continued to be interested. Some might later enter the hospital, but most could be expected to remain in the community. From this beginning many hospitals, communities and states have developed highly organized outpatient services.[1]

ORIGINS

This extension of the mental hospital into the community is only one of the origins of outpatient services. General hospitals also have maintained outpatient dispensaries for a long time. These dispensaries were mainly for persons who were unable to afford private physicians. The quality of medical service they offered was often rather poor. Frank psychiatric cases were not encouraged, and such as came were treated through the general medical department, or later in a department of neurology. The medical staffs of the dispensaries were, for the most part, unpaid.

Specialized psychiatric dispensary service hardly existed prior to the twentieth century. Of course, this does not mean that mentally disordered patients who were without means were ignored completely. A large number of the patients who came to dispensaries were suffering from neuroses or "nervousness," and a distinction was made between them and the frankly mentally ill. In fact psychiatrists, who were preoccupied with more severe mental illnesses, had gained little experience in treating the neuroses. The initiative and leadership in dealing with them came from such physicians as Weir Mitchell, Lewellys Barker, and Austin Riggs. Even today general medical practice continues to be occupied with neurotic disorders, but many dispensaries have also set up specialized psychiatric departments.

A third beginning of outpatient psychiatric service was the department of psychiatry of the medical school. In 1912 the Boston Psychopathic Hospital, and in 1913 the Henry Phipps Psychiatric Clinic at Johns Hopkins Medical School, opened up outpatient services.

A fourth influence in the development of outpatient psychiatry was the child-guidance clinic. The Juvenile Psychopathic Institute in 1909 (later the Institute for Juvenile Research) in Chicago was the first of these clinics (see Chap. 10). In 1917 Healy moved to Boston to open the Judge Baker Foundation (later the Judge Baker Guidance Center). In 1920 the Commonwealth Fund through the National Committee for Mental Hygiene undertook to encourage other communities to establish child-guidance clinics under a high standard of service, with a paid staff and a multiprofessional team of psychiatrist, psychologist, and psychiatric social worker. The early child-guidance clinics also patterned some of their procedures after those of the clinics for the mentally deficient conducted by the state school for the mentally deficient at Waverly, Mass. (now the Fernald School). Technically child-guidance clinics have been deeply influenced by the psychological concepts of Meyer and Freud and have advanced from a beginning which was largely occupied with environmental manipulation as a means of influencing behavior to a more and more refined psychotherapy.

GROWTH OF OUTPATIENT SERVICE

Today the state hospital services have grown measurably. Some of them have adopted the child-guidance-clinic pattern. Many of our medical schools have established large outpatient psychiatric services. Some of these have children's units also patterned after the child-guidance clinic, and in addition there are many independent child-guidance clinics and all-purpose clinics for children and adults which were originally psychiatric clinics for children only.

During the Great Depression and World War II the development of civilian psychiatric clinics was slow. The National Mental Health Act of 1946 gave impetus to states that had previously provided little or no service. In addition this Act expanded the training of professional staff which had for a long time been in short supply. At the same time, 1945, the Veterans Administration launched a new program of mental hygiene clinics which has followed and enriched the best tradition. This program has grown to a network of clinics which now covers the country, although by no means sufficiently.

Today the psychiatric outpatient clinics serve a wide range of cases—in fact, the full range of mental disorders as represented by the official classification discussed in Chapter 4. Some clinics accept all cases; some restrict their intake and specialize in the psychiatric problems of babies, young children, older children, youth, adults, college students, school children, delinquent children, adult offenders, clients of social agencies, industrial workers, etc. Some clinics rather arbitrarily refuse to accept certain types of cases such as the mentally deficient. Some provide psychotherapy only, and cases which are deemed inappropriate for psychotherapy are given a lower priority, even though other forms of treatment may be helpful. It is sometimes forgotten that, even though those of simpler intelligence and simpler ranges of living are unable to produce the intricate life stories, they are still subject to the same dynamic forces. These forces enter into the creation of their problems and by an adapted psychotherapy can contribute to their treatment.

CLINICAL IMPORT

Most patients first come to the attention of a psychiatric clinic because of social problems rather than well-identified mental disorders. They have been the concern of agencies which deal with social problems and which suspect that a psychiatric disorder may be present. The problems, therefore, are identified as child neglect or dependency, adoption, sex deviation, divorce and family discord, family dependency, job failure, alcoholism, delinquency and crime, vague physical complaints, religious quandaries, general school failure, or specific learning difficulty such as in reading.

Since these problems may or may not call for psychiatric attention the referrer should not cease his efforts to provide help, although too often the call for psychiatric consultation is a sign of surrender. Theoretically the call should be a sign that the referrer is alert to the fact that the case may need help *in addition* to what he can give, that the complexity of the problem has outrun his own technical scope, and that he recognizes that he is dependent on other agencies as partners in behalf of the client.

It is impossible to estimate even approximately the number of cases which should be eligible for outpatient service. No person is without problems which might be helped by skilled psychiatric attention. But since these problems are generally the product of many factors, there is also the possibility of choosing among alternate ways of getting help. While one agency may find some problems in a case that are appropriate to it, they may not be the most crucial problems. The specific skills of some other agency may be more needed and effective. In other words, a mere bit of psychopathic disorder is not sufficient as a ticket of admission to a clinic; it should be a crucial bit. But the competencies of clinics and other agencies vary from place to place, so that no universal standard of eligibility can be used. That is why the whole community need and each of its agencies must be understood by a clinic if it is to have a sound intake policy. Also the overtness of a disturbance is not a sound criterion of eligibility. A patient who suffers quietly may need more help than an explosive case.

It has been estimated that some nine million people are in need of psychiatric help and that perhaps some seven million of these can be helped by outpatient services. This figure is very rough but is so far beyond present resources that nothing is gained by refining it. It is well known that in any community where there is a relatively well-developed clinic the capacity of the clinic is far below the demand, no matter how it narrows its function. Long waiting lists are common.

EXTENT OF SERVICE

In arriving at a full appreciation of the significance of outpatient psychiatric services in the promotion of mental health, it is necessary to take into account the extent of their coverage. The essential limiting factor in clinic service is money. The financial limitation of a community enables it to handle only a small portion, perhaps 10%, of existing cases. Any attempt to meet the needs of the 90% by the mere multiplication of clinics is unrealistic. It is necessary either to narrow the field of the clinic, so that it will provide more complete coverage of cases that can benefit from it, or to devise other means of meeting the problem, perhaps on a less refined or on a mass basis. Even the more privileged communities that initiated service in the 1920s have been unable significantly to reduce their insufficiency by multiplying that service. Many clinics are trying to serve more cases than they can serve well. Patients get discouraged, and such long waiting lists confront the new applicant that his problem is solved—happily or unhappily—before his turn for an appointment comes.

In fact large areas of the country have no outpatient service at all. In 1940 a special study of psychiatric service under state auspices by Witmer [2] showed that when little service has been available to a community there is an accumulation of cases of the more severe type—organic neurological problems and mental deficiency. An interesting experiment in rural service is the Rip Van Winkle Clinic [3] at Hudson, N.Y., serving the surrounding rural country. This clinic provides psychiatric services as part of a general medical service rendered by a group of specialists. Rural communities will need to depend upon better training of general physicians and upon better training of the related professions—social workers, clergymen, teachers, public health personnel, judges, etc.—to meet their mental health problems.

There are some 2,100 outpatient psychiatric clinics in the United States, varying greatly in size. Sometimes a traveling staff may serve many communities, some for as little as one day a month. Others are stationary, whereas still others, such as the Bureau of Child Guidance of the New York City public schools, have provision for as many as 24 full-time psychiatrists, with a corresponding number of psychologists and psychiatric social workers.

The number of clinics has increased by over 60% since 1946. Some 400 clinics are aided by the National Mental Health Act passed in that year. Also the Veterans Administration after World War II established a nationwide network of outpatient services of high quality (see Chap. 5). However, in spite of all its resources the Veterans Administration is still unable to meet the demand for outpatient service.

SOCIAL IMPORT

The social import of the problems dealt with in outpatient clinics cannot even be guessed. That it is immense is evidenced by the problems which bring the patients. Most of these problems are serious socially.

Many are part of a chain reaction or vicious circle—the disturbed child of the disturbed parent later becomes the disturbed parent of another disturbed child unless the vicious circle is broken by the clinic or some other intervention. In that sense the clinic may be considered preventive. However, clinics for children are really concerned with early treatment rather than prevention. Still they could, if so conceived and properly equipped, be truly preventive and in that way compensate to a degree for their limited coverage. Case studies offer a clinic three types of preventive opportunity:

1. They identify persons in the community who so misunderstand the problems of mental ill-health that they fail to give help when it will do the most good. For such persons they can give and mobilize needed education.
2. They identify conditions in the community that are conducive to mental disorder. This lead calls for social action such as legislation or better community organization.
3. They identify the deficiencies of science. The answer to this lead is research.

While they are in a key position to lead the community in the pursuit of these three challenges, clinics have usually ignored them.

Many a patient for whom outpatient service would have been preferable has been hospitalized because no clinic was available. The cost of good clinic service is great, but it still is cheaper than good hospital service. Whenever a patient must be hospitalized because no clinic exists, the taxpayer must bear an additional burden, and the patient is given second-choice treatment.

In still another way outpatient clinics conducted in conjunction with mental hospitals have social value. They show the public that the state is concerned with all degrees of mental problems, not merely with those requiring legal commitment. By concerning itself with milder outpatient problems the hospital loses some of its stigma. It becomes less ingrown and isolated. The staff of the hospital comes to know the communities better and is known to the public. The staff members acquire a breadth that helps in their understanding and treatment of the patients who are in the hospital.

SCIENTIFIC STATUS

Because clinics deal with many cases in which the causes are nearer at hand than when hospitalization is needed, they have contributed well to our scientific knowledge. The American Orthopsychiatric Association, as well as other psychiatric, psychological, and social-service organizations, provides a forum for the scientific contributions of clinics. The membership of this association is composed of the professions found on clinic staffs. Its journals, as well as the journals of the other scientific associations, report scientific progress in outpatient services. Every aspect of clinic work, from the process of application to that of follow-up and evaluation of results, has been subjected to critical scientific study. However, much of the service rendered is still based upon hypothesis rather than full scientific validation. This is inherent in the complexity of the field and the difficulty of setting up scientific control cases.

Still there is wide enough agreement among the professions to identify good service and enough disagreement to stimulate research. Psychotherapy, often accompanied by environmental change, is the major treatment device in clinics. Some use electroshock and other such therapies, but these call for special facilities and safeguards. Psychotherapy cannot be a uniform process, since it involves the personal qualities of the therapist as well as some standard principles of the techniques of treatment. For this reason clinic personnel enjoys great leeway in the use of ethical and approved methods. Good staff supervision is therefore a necessary safeguard and balance to this professional autonomy. In fact the techniques of staff supervision have been to a great extent developed in outpatient clinics. Some clinics develop a special competence in handling certain problems and in using certain diagnostic and therapeutic techniques. Clinics vary also as to the responsibilities carried by different members of the staff. This enlightened liberality of clinics allows the staff to pursue through research the leads that come from work with patients.

PROFESSIONAL PERSONNEL

Of course science is of little value unless it finds its way into the training of personnel. Since the early 1920s there has been a serious shortage of personnel qualified for outpatient service. This shortage of psychiatrists goes back in part to the inadequacy of psychiatric education in medical schools. As a result of this inadequacy few physicians have in the past been intrigued into choosing psychiatry as a career. Even those who prefer psychiatry have been often trained in hospitals and have had little experience with children, with community problems, and with neuroses. Many also have had little opportunity for teamwork with psychologists and psychiatric social workers. More recently the attractiveness of private practice has competed seriously for clinic personnel. To overcome this shortage the National Association for Mental Health for many years provided fellowships for training planned jointly and provided by a number of clinics. In 1944 the National Association for Mental Health, recognizing that this is a professional rather than a citizen function, sponsored the formation of a professional association, the American Association of Psychiatric Clinics for Children, and in 1946 transferred to it the responsibility for the further development of training and the selection of fellows. It is interesting that during World War II those who had had this type of training proved to be especially competent in meeting the problems of young adults in the Armed Forces. This really means that preparation for outpatient child psychiatry gives an exceptionally good understanding of the causes and dynamics of mental deviation in the making.

The shortage of psychologists is somewhat less than formerly, because training now includes better-planned clinical experience. There are more training centers and more trainees. Formerly the psychologist was occupied chiefly with the application of tests and measurements of mental abilities and achievements. Then children with educational disabilities provided an opportunity for the psychologist to join with the rest of the staff in treatment as well as diagnosis. More recently psychologists have participated increasingly in the psychotherapeutic work of the clinic. This discipline has thus become more attractive. The National Institute of Mental Health and the Veterans Administration have done much to advance the training of clinical psychologists and reduce the shortage in this field.

The supply of social workers for clinics has for many years also been insufficient. The cause lay, first of all, in the rapid development of competing fields of professional social work and the demand throughout the field for those who could bring in the "psychiatric viewpoint." Now that a knowledge of the dynamics of human behavior is basic to all social work, the specific training in psychiatric social work is delayed until the latter part of the curriculum. Also many clinics that make no provision for a period of supervised work for beginners in social work are not attractive to graduates.

A few clinics have experimented in using the nurse on their staffs. While clinics generally have collaborated closely with public health nursing agencies, the distinctive function of the nurse within a clinic has not yet been well defined, and the demand for nurses in clinics is still very limited. The National Institute of Mental Health has encouraged experimentation in the participation of the nurse in clinic work, since many clinics are conducted by departments of health.

INTERAGENCY COOPERATION

Clinics receive their cases from a wide range of community agencies as well as through direct application by patients and their families. They must therefore very often collaborate with one or more community agencies that are at the same time dealing with the patient. Clinics, in fact, were among the first community agencies to see that only by close collaboration could the integrity, i.e., the oneness, of the patient be respected. Collaboration also results in mutual education. However, a clinic retards community progress if it accepts cases which the referring agency could have served better had it been properly equipped. Excessive case loads or inadequate staff training especially cause such referrals. If the clinic can help overcome these deficiencies it is good practice as well as good economy for it to do so, for a client or patient suffers some loss when he is shifted from one agency to another. The prospect of gain should be good to justify the shift. Some clinics invite a worker from a collaborating agency to participate in staff conferences on the case, or conversely a clinic staff member may participate with the staff of another agency. This crossing of agency boundaries is in keeping with the highest concept of community function wherein every agency is seen as dependent on the rest.

Many staff members of clinics devote some time, especially evenings, to community education and to participation in other general community activities. Clinics also collaborate with professional schools and hospitals by offering opportunities for trainees to secure outpatient experience. If this training is done well it adds to the expenses of the clinic, for good supervision costs more than the value of the service rendered by the trainee. On the other hand, a training clinic finds it easier to recruit personnel, and the training it provides helps other agencies to secure personnel better acquainted with the clinic and better able to collaborate with it.

CLINIC ORGANIZATION

Clinics vary somewhat in the composition and balance of staff. Some use only psychiatrists. Some appear on the surface to have a multiprofessional team, but the several professions on the staff work quite independently. Others have a true division of labor and carry on most of their work jointly. They depend upon case conferences to integrate the work of staff. In most clinics the responsibility for directing the staff is in the hands of a psychiatrist, although it is not unusual for the director to delegate administrative duties to others.

Experience over the years has clarified many of the conditions which contribute to the effective operation of a clinic. These are dealt with extensively in a booklet entitled *The Organization and Function of the Community Psychiatric Clinic.*[4]

Clinics operate under a variety of auspices such as mental hospitals; state mental hospital departments; health departments, state and local; Federal departments; schools and universities; courts, social agencies, and churches. There is no clear definition of the function of the state and the local community in providing psychiatric outpatient service. Many clinic cases are not an accepted responsibility of the state, yet many of them are. Traveling clinics are, as a rule, under state auspices. Still, when one considers that most of the causes of mental disorder can be attacked only locally, there is good reason for placing some responsibility in local hands. Some state traveling clinics accordingly require the community to participate in the support and control of the clinic.

At times fear is expressed lest the alliance of a clinic with a state hospital may stigmatize it in the eyes of the public. This may sometimes happen, but the fact that such clinics have waiting lists indicates a readiness on the part of the public to use them, and conversely the clinic may in fact help to reduce the stigma of the state hospital. In some states there is competition between health departments and mental hospital authorities for the administration of clinics. This is in part fostered by exaggerated claims that the clinic is a preventive agency. Of course, health departments very appropriately carry on activities which are intended to be truly preventive. Some mental hospitals, on the other hand, would gladly give up outpatient work and retreat into comfortable isolation.

From time to time the proposal has been made that mental health centers—or, even more broadly, health centers—be established in communities to help maintain close relations among the many state and local health services. The Hill-Burton Act (Federal hospital construction) actually provides for Federal assistance in constructing such centers. New York State shares the cost of local mental health services when communities establish a local mental health board for the planning and conduct of these services.

The financing of clinics is just as varied as their auspices. Some are publicly financed, some privately. Some have a distinct budget, whereas others are supported as a part of a general outpatient service, or as a part of a hospital budget. Some clinics have attempted to meet their expenses by charging fees, but most who charge fees do so in order to free the patient of a feeling of obligation and to normalize the doctor-patient relationship. Fees, in fact, seldom constitute a good source of support for a clinic.

Clinics are, as a rule, the first thought of those who want to advance mental health. But a clinic to be sound must be carefully designed. It should be preceded by a careful community study to determine what agencies bear upon mental health, how they can be strengthened, how they can best be related to a clinic, and how a clinic's effort may best be spent.

RESIDENTIAL SERVICES

In the early days of child-guidance clinics it soon became evident that residential facilities for emotionally disturbed children were needed both for observation and for treatment. Today a small number of public and private hospitals or institutions for mentally ill children exist, sometimes associated with outpatient psychiatric services. Some of these evolved from older institutions for children with behavior disorders, including delinquency and mental deficiency, when they discovered how prevalent emotional disturbances were among their children. Some evolved from institutions for dependent children (orphanages) in much the same way. The Child Welfare League of America, pursuing a principle that a child is best reared in a family rather than in an institution, was instrumental in converting some orphanages into study and treatment homes for emotionally disturbed children. In 1952 this League published a detailed study of 12 residential treatment centers.[5] A few proprietary institutions for emotionally disturbed children were started as such, but for the most part these proprietary institutions began as schools for the mentally deficient.

About 1918 the occurrence of a new disease—chronic epidemic encephalitis—highlighted the lack of facilities for mentally ill children. This disease produced such a terrible upheaval in the behavior of its child victims that existing state hospitals could not care for them properly.

New York State shortly developed children's units in two of its state hospitals, one for children with organic brain disorders and the other for those whose illness came from more obscure causes. Several other states since then have established special provision for mentally ill children, sometimes as part of a large mental hospital and sometimes separately. A pioneer unit was also established by New York City at Bellevue Hospital, where outstanding work has been done on the diagnosis and treatment of schizophrenia in children. Still even now in most states mentally ill children must be cared for by makeshift arrangements in institutions designed for other purposes.

About one thousand children are admitted each year to state hospitals for the mentally ill. The problem is, therefore, not a relatively large one numerically. But present knowledge indicates that severe cases are most likely to become lifelong problems for the state. About half these children are classified as psychotic, two-fifths of them being reported from New York State alone. About 200 are cases of epilepsy and mental deficiency. On the basis of the prevalence in New York State, it is estimated that in the whole country there are about 1,500 new cases per year. The provision —good and bad—is for about 350.

Epidemic encephalitis has receded since the 1920s. Childhood schizophrenia, which accounts for about one-third of the psychotic children, is an especially grave condition with poor outlook. Whether or not it is the same disorder as adult schizophrenia is still an open question.

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14 NONPSYCHIATRIC AGENCIES SERVING THE DEVIANT

Previous chapters have dealt with agencies which were created to deal with mental deviation. But every other agency that aims to help people who are in trouble must deal with mental illness in varying degrees. There is the court, whose work with offenders was discussed in Chapter 10, and there is the physician, discussed in Chapter 8. There are organizations such as the Salvation Army and the Red Cross, and there are agencies for family service, child welfare, financial assistance, vocational rehabilitation, public health nursing, travelers' aid, marital counseling, legal aid, etc. All these must render help to persons with mental disorders, and their professional personnel are trained to do so.

An understanding of several of these agencies will help us understand all, for the same considerations arise repeatedly with all of them. Each of these agencies has a national organization which is concerned with standards, training of personnel, conditions, bearing on their work, and providing the public with information. They are described in the Social Work Year Books.[1]

MENTAL DISORDER AND SOCIAL PROBLEMS

Mental disorders reveal themselves in a wide variety of ways. In some cases they are obvious. Others appear in the form of social and economic breakdown, and it is a part of the skill of social agencies to sense the likelihood of mental disorder and to take appropriate action. With the help of psychiatric consultants they often enable such clients to get along in the community. In some cases the major responsibility must be transferred to a psychiatric agency, while the social agency continues to provide services cooperatively. Sometimes the two work together practically as a single team and thus ensure a more complete integration of their services.

Of course most of the beneficiaries of social agencies are emotionally disturbed—some quite normally so, in view of the stresses under which they live. A part of the competence of such agencies is to sense the seriousness of the emotional disturbance and the need for consultation to tide clients over emotional problems. This calls for a distinction between the techniques of psychotherapy and those of social case work. The distinction is often hard to make, for there is no sharp demarcation between them. But typically psychotherapy calls for a greater concentration upon the genesis and modification of habitual psychological tendencies that lead to the patient's disordered behavior. Dealing with the current life problem is secondary. Typically the nonpsychiatric agency is occupied with helping a client more directly to a constructive attack upon the problem at hand.

The causation of mental disorders must be understood to appreciate the role of the nonpsychiatric agency. It is generally agreed that mental disorders are brought about by the combined effect of many causative factors. Some of these consist of unfortunate experiences through which an individual has passed and which undermine his resilience and reduce his reserve capacity. Some are bodily disorders. Some are hereditary, and some are really disorders of the society in which he lives and the culture in which he has been reared. Some of these factors can be modified by the techniques of psychiatry. Others call for skill in bringing about modifications in the social setting. Some can be reduced by financial help. Sometimes the family needs help in achieving a better balance and serving its members better. Often the home and family have disintegrated and substitutes must be found. This is especially a concern of welfare agencies. In brief the multiplicity of causative factors in any one case offers many agencies the opportunity to lift an offending last straw and enable the victim to regain balance. Consequently those who are skilled in dealing with any of these factors may improve the adjustment. They are psychiatrically valuable even though their techniques are not psychiatric.

Some mentally ill patients have received all the help that clinical service has to offer. The social agency may then attack the problem through a different set of causes and the use of a different set of techniques. It may merely reduce the social risk to the patient or community or it may contribute to his recovery. Sometimes where psychiatric service is not available in the community as an alternative the problem is dealt with by focusing attention on factors in the handling of which the social agency is expert. This viewpoint of the function of a social agency in dealing with mental disorders, of course, assumes that the agency's staff is adequately trained and experienced, and that case loads are small enough to permit a well-trained staff to exercise its talents.

Since the boundaries between a mental disorder and other forms of social and behavioral deviations are not clear-cut, it is impossible to count cases accurately and determine the number of mentally ill who are served. It is in fact furthermore often a distinct disservice to a patient to force this distinction, for it tends to limit the approaches that are made to his problem. His problem has no such sharp limits as the diagnostic category seems to imply. His needs are better respected when a free flow of service is provided between agencies, each one drawing into effect the special competences of the others.

THE FAMILY AGENCY

A major force in bringing psychiatric service into a working partnership with the nonpsychiatric agencies was the child-guidance clinic. Already in the early 1920s these clinics were working out the processes of interagency collaboration. At that time the impact of psychiatric social work on other areas of social work was so great that more and more persons trained in psychiatric social work were being enlisted by these agencies. They helped to build up a greater concern for and capacity to deal with the mental and emotional problems which induced or aggravated the problem which the agency was trying to solve. At the same time schools of social work were equipping their students increasingly to understand the forces at work in shaping behavior and how these forces could be turned to the advantage of the client.

Another important factor in developing the competence of these agencies was the depression of the 1930s. Prior to that time the refined type of work which focused intensively on the client and the forces that shaped his behavior occupied but a small portion of the work of the voluntary agencies, and usually the public agency did not operate at a professional level. The family agencies were largely occupied with giving financial relief. With the depression a great change occurred. The need for financial relief became so great that it exceeded the capacity of the private agency. As a result public agencies took over the major task of providing financial assistance.

The sudden demand for staff by the public agencies brought many entirely untrained people into the field. Since then, however, many public agencies have acquired qualified social work staff capable of sensing and dealing with the psychological as well as the economic forces that produce dependency. This development of professional social work has done much to eradicate the almshouse, the orphanage, and the overseer of the poor, upon which the first years of the twentieth century largely depended for meeting problems of poverty.

When the private agencies were relieved of the major responsibility for financial relief, it became possible for them to focus more exclusively on intensive personal case service.[2] Many of them at that time engaged psychiatric consultants to assist both in case study and interpretation and in staff training.

While teamwork between the agencies that deal primarily with the mentally ill and those that deal with social problems makes good sense, there are resistances to collaboration. Those who compose the staffs and boards of social agencies are just as susceptible to the temptations of administrative ease as are others. They tend to avoid functions that complicate their administration. This institutionalization may not be as fixed in social agencies, since they are, as a rule, located in the center of a community rather than in the more remote hinterland and are not restricted in their perspective by bricks and mortar. They are inescapably forced into contact with other agencies. In fact, they are often located in the same building with other agencies. A client with a mental disorder will sometimes sorely try a social agency to the point where it is tempted if possible to shift the responsibility to other shoulders. For example, not uncommonly a social agency will try to shift the responsibility for the mentally deficient to a state institution, whereas it might be better for the client to solve his social problem in the community.

"Hopeless" Cases. Under the pressure of work and limitation of resources, social agencies tend to develop a hard core of cases for which their ordinary processes have proved inadequate and which are considered hopeless. Under these conditions there is a tendency to seek other means of meeting the problem outside the structure of the agency rather than the development of greater strength within. Thus it is not rare to find

that the demand for the establishment of a child-guidance clinic in a community comes from the fact that other agencies are not doing all that they could be doing if their own development were adequate. When an agency is relieved of responsibility for its difficult cases, the staff is almost certain to become pauperized professionally. In general the private social agency has been freer to choose its cases and limit its intake so as to provide for the mentally handicapped within its clientele.

But concentrated work on those "hard-to-reach" cases, using processes of environmental manipulation in addition to the more personal case work, shows that many are not beyond reach. The provision of such intensive service calls for a higher degree of support, staff, and other provisions, which unfortunately many agencies do not possess. Most of these cases could be considered psychiatric problems, but the effective approach calls for other techniques than those which are used in psychiatry. Redl[3] of Wayne University School of Social Work has carried out experiments on the rehabilitation of boys who have become the despair of other agencies. An experiment carried on in New York by the Brooklyn Bureau of Social Service[4] has shown how much can be done with concentrated effort in these cases.

On the other hand, the social agency has a distinct advantage by its location in the community. Like the outpatient clinic, it comes to appreciate the conditions in the community that have contributed to social and psychological disorders and is aware of the deficiencies of service such as the need for a psychiatric clinic. It is thus in a position to foster improvements in the community that will make for better mental health of all persons.

THE CHILDREN'S AGENCY

In Chapter 13 it was pointed out that some orphanages had been converted into study homes for emotionally disturbed children. Some residential institutions have served as temporary shelters to tide children over a disturbance in their normal family situation, such as the mother's illness. But the traditional orphanage is a paradox of civilization masked as benevolence. Among many "less civilized" peoples there is no such need. The bereft child is adopted spontaneously by another family which takes it into its bosom as its own.

Modern science has shown how right this is. Food, clothes, and shelter are essential, to be sure, but the child will cling to simple food, poor clothes, and leaky shelter in preference to refinements if along with the former there is a place in a family and affectionate parents and siblings. These are essential to his sound mental growth. Yet this is exactly what the congregate institution, with rare exceptions, is unable to give. The late C. C. Carstens, of the Child Welfare League of America, long ago pointed out how deadly an institution can be. It was not so clear then as it is now that the fatal outcome for so many children in institutions was aggravated by the utterly devastating effect of living without love. Spitz [5] has shown how serious a physical decline can come from this emotional impoverishment. Even temporary separation from parents during the hospitalization of a child is serious enough to justify more liberal visiting arrangements for parents. The Negro family of the Deep South, limited in wealth but characteristically warm of heart, dealt most humanely with its orphaned neighbors when it adopted them informally and without discrimination. It seems almost as if the preoccupation with the material values of modern civilization has obscured the primacy of human values.

Even the replacement of the orphanage by a foster home is only a partial gain if the foster home can give merely food, clothes, and shelter. The demand for adoptive children is high. Adoption has saved many, but often adopted children have been permanently damaged before the opportunity for a real home comes to them. The unattractive child, who needs a home most, is still badly off. The World Health Organization has recognized adoption as a health matter important enough to issue a technical report on the subject.[6] It stresses the need for parental feeling as a basis for adoption. It calls for a good marital relationship between the adoptive parents, including mutual love and respect. It senses the desirability in an adoptive parent of readiness to accept imperfections in the child just as natural parents do. If it is asking too much of an adoptive parent to accept the child wholeheartedly no matter what deficiencies turn up, it is important to see that a child be chosen within the parent's capacity for acceptance. In view of the influence of the early weeks and months on emotional growth, early adoption is to be preferred. The older the child the more is the need for gradual change-over with as much preservation of the old as is compatible with the new home. When adoption does not occur, the next best, whether in a foster home or even an institution, is a mother in the sense of a loving and lovable foster mother.

The church has been the traditional and at times the sole buffer against hunger and cold and has provided the auspices of many social agencies. These agencies have advanced as the behavioral sciences have expanded. Few church agencies any longer consider, as many once did, that an attempt to understand the psychological forces at work in making life a trial is a denial of divine will or a bypassing of the resources of divine benevolence.

PUBLIC ASSISTANCE

The Federal government provides financial assistance to the states in meeting many problems of social failure. A 1950 amendment to the Federal Security Act, previously referred to in the discussion of county homes, provides for Federal grants to the states for the care of disabled persons. But some states take little or no advantage of this Act. The lag is in part due to the absence of state legislation to authorize the use of such Federal grants. Accordingly, three years after the passage of this amendment, while 39 states were taking advantage of it to some extent, only 20,000 persons were aided. In order that the mentally ill may enjoy this assistance, there is need of experiments to develop methods of determining eligibility[7] and of applying these services. Since this assistance is not provided, as a rule, through the particular state authority that is concerned with the mentally ill, there is also need for developing better processes of interdepartmental cooperation.

Another reason for the slowness of the states in taking advantage of public-assistance provisions for the mentally handicapped is that the disability of the mentally ill is not so obvious as that of the crippled. However, psychoneurotic patients and those with delusions of persecution are often completely disabled. Furthermore, the crippled themselves are often more disabled psychologically than physically. The public, however, tends to be less sympathetic toward and tolerant of disability that is due to psychological limitations.

Federal assistance for the mentally disabled requires that the disability be permanent and total. However, this stipulation of the Act is administered liberally. A disability may be considered permanent when the prospect of its termination is uncertain. In the provision of public assistance to disabled persons the first task is to determine whether the disability is wholly or in part currently remediable through vocational rehabilitation or other services. The mental health aspects of vocational rehabilitation will be dealt with later in this chapter.

Public assistance to the mentally handicapped and in fact to all disabled persons is not merely an alms. It is rather a means of rehabilitation. It calls for participation by family and friends. The members of the family need to be brought to a point where they can consider public assistance as one way of aiding them in achieving a higher level of functioning by the recipient and not just a dole which will help meet the expenses of his care. Public assistance is at its best when all the state and local services that may be helpful have been taken into account. It may, for example, be more appropriate to have the patient admitted to a state mental hospital where he can get technical help in the treatment of his problem than to accept his disability as static. While the first step in any case is to determine which of these other services the client needs, this cannot be a one-sided effort; other parties to the collaboration, namely, the other state services such as vocational rehabilitation and mental hospitals, must be receptive and pursue the same enlightened principle. Accordingly patients admitted to or being discharged from a state hospital should be reviewed from the standpoint of their eligibility for public assistance and the extent to which this service would help to rehabilitate them.

Public assistance would be especially appropriate for persons who are receiving vocational training but who are currently unable to maintain themselves. Public assistance is also appropriate for former hospital patients who have been placed in boarding homes under adequate supervision. In some cases the patient may need only visiting-nurse or housekeeper service. In such cases the public-assistance agency may claim Federal reimbursement for the costs of these services as an administrative expense.

VOCATIONAL REHABILITATION

The Federal government makes provision also for those whose disability is fixed but not complete and who can with proper training and placement resume a productive life. The relation of work and mental health appears frequently in psychiatry. Case studies show that unwholesome work often contributes to, aggravates, or precipitates mental illness. There are also indications that relapse is less frequent among recovered patients who have secured suitable work. This does not mean that some types of work are per se unwholesome while the remainder are good. That is too easy a concept and one that can work great damage. Some would like to believe, for example, that a job on a farm is good and wholesome for anybody. A job that is just right for one person may be unwholesome for another.

In spite of these principles there is a surprising paucity of carefully conducted research designed to show how the work life of a person has a bearing on the maintenance of his mental health, the production of his mental illness, or his return to a mental hospital. Work and mental health is the subject of Chapter 21.

In 1943 Congress passed the Barden–La Follette Act, thereby extending the benefits of vocational rehabilitation to the mentally handicapped. Under this Act a state could obtain Federal assistance in the vocational training of mentally handicapped persons, including those about to be discharged from its mental hospitals, as well as those in the community. In fact through this Act medical, psychiatric, and psychological examinations may be provided "to determine the extent of disability, possible hidden disabilities, special talents, work capacity and eligibility for service and to remove the disability." [8] Counseling and guidance are also included in the benefits. A working definition of a mentally handicapped person as applied in the administration of the Federal Act is one (1) whose employment has been terminated as a result of his mental disorder, (2) whose prolonged illness has resulted in deterioration of skills, (3) whose health or that of others is jeopardized by vocational placement in which he may have skill, (4) whose disability interferes with preparation for a job commensurate with his ability, (5) who is rejected from positions because of his illness.

However, several years passed before states began to take advantage of this opportunity. In 1951 only 2,691 mentally handicapped persons were returned to work under this Act, and only one-fourth of these had been psychotic.[9] The lag was due partly to lack of experience on the part of both the psychiatric services and the state vocational rehabilitation service in working together. Also the extent of the need for this service has never been determined. Over and above these two factors there was a third constantly reappearing influence: that of administrative ease, i.e., the reluctance of the institutions and agencies to take on complicating responsibilities. The Veterans Administration, in contrast to the state institutions, has a long record of serious attention to vocational assistance to its patients.

In order to overcome the first two of these factors two experimental projects were undertaken by the National Association for Mental Health.

Through the first [10] it helped several hospitals to work out the routines of vocational rehabilitation. This project showed that about 15% of the patients discharged from mental hospitals were in need of vocational service. The second [11] project was similarly concerned but dealt with outpatient cases. As yet no comparable experiments have been conducted on behalf of the mentally deficient or the epileptic. The Office of Vocational Rehabilitation has, however, published a symposium *Vocational Rehabilitation of the Mentally Retarded*.[12]

But the third factor, administrative ease, still retards the extension of this service. It requires more encouragement than evidence of feasibility to influence institutional routine. The office of Vocational Rehabilitation has assigned one staff member to give special Federal attention to the mentally handicapped. The National Association for Mental Health also has outlined activities that should bring about more rapid progress, but has been unable to put these into effect. To encourage progress in a particular hospital, it is important first to determine why it has not used vocational rehabilitation services. As a first step a conference should be arranged among the state psychiatric authority, the state vocational rehabilitation authority, and the state employment authority in order to plan for joint action. It may be necessary to import an experienced person in each of these fields as a consultant from another state. It may be necessary to secure special funds from the Federal Office of Vocational Rehabilitation or some other source to launch a demonstration project in a favorably situated hospital. It may be possible to bring about the employment in the state vocational rehabilitation program of one member especially responsible for this phase of the work. But a vigorous effort is needed locally as well as statewise, for it is in the community that people live and work. It is in the community that the need for training facilities exists. It is in the community that jobs must be found and that deterrents to the employment of the former patients must be combated. It is in the community also that the agencies exist which can continue to maintain a contact with the patient to determine whether his vocational training and placement have been successful.

In 1954, amendments to the hospital-survey and -construction act provided for assistance to the states for the construction of rehabilitation facilities. Additional legislation extended hospitalization to reduce disability. Aid was also authorized for the initial equipment of rehabilitation facilities and sheltered workshops, including private nonprofit as well as governmental facilities. Provision was also made for the application of vocational rehabilitation to potential recipients of old age and survivors' insurance who suffer disability before 65 years of age.

But the value of vocational rehabilitation to mental health is not limited to the mentally handicapped. It is well known that the greatest handicap of many physically disabled persons is the psychological disturbance that comes from comparison and competition with normal persons. Two persons with equal crippling will present very different problems of rehabilitation, and much of the time, skill, and effort of rehabilitation personnel is used in overcoming psychological obstructions. The habit of dependence is often so ingrained in the handicapped person that he resists efforts to put him on his own feet. He is afraid of independence.

There is no present measure of this psychological disability of the physically handicapped. Nor do we as yet have the experience to warrant a good estimate of the social and individual import of vocational rehabilitation to the mentally ill. According to the studies previously referred to, about 30,000 hospitalized patients per year need vocational rehabilitation. In addition there are equally serious cases in which persons who have not been hospitalized need vocational rehabilitation.

It is clear that the staff counselor in a vocational-rehabilitation service has need for exceptional skill in sensing the presence of a disturbance of mental health in persons with any form of handicap, as well as the mentally handicapped themselves. There is today a general shortage of staff trained to carry out these functions. Before the mental health needs of the handicapped can be met, there must be both budgetary provision for personnel capable of meeting the need and training centers in which such personnel can be prepared.

TRANSIENT SERVICES

Certain agencies deal largely with a transient clientele and have only a brief period in which to give help. Often such an agency has only a matter of hours to render its full service. It encounters many problems of severe mental disorder of which transiency of residence and traveling may be a symptom. Circumstances have forced this kind of agency to develop effective techniques that contrast sharply with the more deliberate process of other social agencies.[13] There is neither the time to build up the most effective human relation that is based on mutual understanding nor the time to work with the client to bring important but obscure factors into the open. Yet effective work is done which contributes greatly to the tiding of clients over emotional crises. This short-term case work proved to be of value during World War II both in the United Service Organizations (USO) and in the Red Cross. Also military mental hygiene clinics very often had limited time in which to serve the patient because of rapid movement of personnel. But Travelers Aid Societies are the outstanding community agencies in this category.

LEGAL SERVICES

Troubled people are the stock in trade of lawyers. The range of their encounter with mental and emotional disorder is tremendous. The lawyer's client with litigious personality is familiar to psychiatrists as the paranoid patient. The full-blown paranoic or paranoid schizophrenic with his repeated recourse to habeas corpus is the bane of the lawyer's existence. Quite apart from the legal processes that attend the handling of the mentally ill, the lawyer encounters lesser but still severe emotional disorders at every turn. The very prospect of litigation throws many persons into a panic. Domestic problems, especially separation and divorce, are more often than not the outgrowth of mental deviation and emotional immaturity. In the words of President Seymour [14] of the Legal Aid Society of New York: "Reports deal in statistics; our lawyers don't, they deal in the puzzling worries of individual people." A large body of psychological knowledge and technique has been accumulated about interviewing, but this has been given little place in the training of lawyers. Still, much of the service rendered by a lawyer depends upon the interview with his client. As much as 40% of the cases served by the Legal Aid Society of New York are completed with one interview. This means that a high degree of skill is needed. To some lawyers skilled interviewing comes intuitively, as it does to those in other professions dealing with human problems. Others need a more designed preparation. Among the agencies of the community that deal with the mentally ill incidental to another motive, the Legal Aid Society often passes unnoticed. But since it serves a clientele of lower economic status, it sees an exceptional number of persons of limited mental competence.

COMMON PROBLEMS

As one looks at these nonpsychiatric agencies in perspective he finds each one faced with the same situation:

1. They are participants along with others in the treatment of mental problems. Some of these problems are essentially mental illnesses; some are social problems caused by mental disorders; some are social problems which cause, contribute to, or aggravate mental disorders; and in some the mental deviation obstructs the treatment of problems which otherwise would be quite treatable.
2. They deal with many mental cases for which psychiatry is not available or desirable.
3. Their quality is limited by case loads and staff training.
4. The distinction between their cases and those of a psychiatric clinic and hospital is not always clear. The cases of mental deviation, therefore, cannot be easily counted.
5. Their value to the person served is augmented by interagency cooperation.
6. They tend too easily to relinquish responsibility to another service instead of fostering internal growth. This pauperizes the staff professionally.
7. They often become preoccupied with instrumentalities, techniques, and administrative routines to a point where a client ceases to be the focus.
8. Through their work with cases they discover community defects, but they have not realized their potentialities for leadership and preventive work.

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PART THREE

The Protection of Mental Health

15 PUBLIC HEALTH AND THE PREVENTION OF MENTAL DISORDER

Previous chapters (Chaps. 3 to 14) have been concerned with mental disorders and the social institutions which relate to them. The services are predominately psychiatric. But some cases become the responsibility of nonmedical agencies: correctional institutions, courts, police, social agencies, and others. The psychiatric service is then auxiliary. These medical and related agencies focus their efforts on deviations from normal living, and the goal in any case is restoration to health. In this chapter the viewpoint shifts from the restoration of health to the protection of health. It shifts from the sick to the well. It shifts from the medical practitioner and his associates to the public health officer and his associates, among whom is the medical practitioner. The key concept is prevention, not treatment.

PREVENTION

The hope of all who deal with mental disorders is that ways may be found to prevent them. But the goal is not as simple as mere knowing. It is not always sufficient to know what will overcome a causative factor, for prevention sometimes requires a modification of some fixed social customs. The price of prevention may be the surrender of values which society is unwilling to give up. Mental disorder in some of its members is not the worst disaster that can befall a people. Social perspectives must, therefore, be maintained so that precious social values may not be traded too lightly for insurance of individual mental health. For example, those who have endured an underprivileged position—suppressed people—may achieve a degree of adjustment to their plight no matter how much they may resent their suppression. When they are finally liberated, their habitual dependent ways of life and their values and relationships with others may block their making the most of and adjusting to new freedom. Under these conditions neurotic susceptibilities are likely to be aggravated. The isolated rural Southerner of the United States or the Puerto Rican transplanted to the urban North often becomes mentally ill as a result of this change, especially if he is already vulnerable. Some of these casualties might be prevented by restricting migration. But such an infringement of human rights is intolerable in a democracy. Instead it is expected that the communities in which they settle should try, perhaps with Federal help, to facilitate the adjustment of the immigrants. Or, to take another example, the regimentation of the German army is reported to have been responsible for its having lower incidence of neurosis than our own. Such regimentation is, however, incompatible with democratic values in the United States.

Efforts at prevention may be disastrous if they are superficial. Unusual behavior is sometimes a fumbling effort to solve an underlying problem and not in itself a cause. But a preventive effort that focuses only on stopping the behavior deviation and that does not consider the full depth of the problem is of uncertain value. Merely blocking a poor attempt to solve a problem may result in personality deterioration that is even more serious than the problem. For example, the alternative to mild alcoholism may be suicide or a more serious mental illness. It is the problem which the victim tries to solve by alcohol that needs to be dealt with before his crude solution is made the point of attack. Personality growth comes from fighting problems through, even to a partial solution. For this, help may be needed.

The term prevention cannot have a specific meaning unless it is made clear whether it refers to (1) absolute prevention, (2) presumptive prevention, (3) relative prevention, or (4) prevention of relapse.

Absolute Prevention. With a problem as complex and variable in its causation as mental deviation, it may be expected that prevention will, as a rule, be correspondingly uncertain. In fact there are only a few forms of mental disorder whose causes are at all certain. These include general paresis, due to syphilis of the brain; pellagra, a brain disorder due to a niacin vitamin deficiency; alcoholic psychoses; mental illness due to brain injury; drug psychoses and addictions; and mental deficiency due to rubella in the mother during pregnancy. These are the mental disorders of which the essence of prevention is well known. To that extent it may be said that they are absolutely preventable.

This can be said of them, however, only with reservations. In the paths to prevention there are often psychological blocks that arise from other forms of mental ill-health. For example, the inability of certain people to drink alcohol in moderation is itself a symptom of mental disorder, usually a neurosis in which alcohol is used as a narcotizing defense against painful anxiety. These underlying disorders are quite different from the mental illnesses that result from the toxic effects of alcohol. Furthermore, the prevention of these neurotic disorders is still quite speculative. Consequently the prevention of alcoholism is very complex. Similarly dietary faults that lead to a niacin deficiency and pellagra are sometimes akin to neurosis. Sometimes the local dietary customs are at fault and may be equally resistant to change. In spite of this it has proved possible almost to eliminate pellagra. Head injuries constitute another cause of mental illness that may be materially reduced in industry by aggressive safety provisions. Still, many accidents are caused by accident proneness, a condition that is again neurotic in character. Greenwood and Woods, as quoted by McLean,[1] have shown that a vast majority of the accidents are suffered by 20.0% of the employees. Sexual promiscuity, a factor in the spread of syphilis, which causes paresis, has also been shown to be largely the expression of deeper mental disturbances. Hence, although paresis may be directly preventable, a much more complicated problem presents itself in the preventive aspects of sexual promiscuity. These few preventable disorders constitute but 13% of the total psychoses admitted to state mental hospitals and, of course, a much smaller percentage of all mental disorders.

Presumptive Prevention. Most of the effort to prevent mental illness is not as well supported scientifically as absolute prevention. Since certain apparently contributing factors recur frequently in the histories of the mentally ill, it is concluded that the elimination of these factors will prevent the disorder. This reasoning evades the fact that mental disorders stem from a multiplicity of factors, of which these apparent ones are only a portion—how great a portion, we do not know. Furthermore the force of any one factor probably varies from case to case. We have not tested the preventive value of removing these factors. We do not know how well the inherent defenses and resistances of a person can cope with threats to mental health. We do not know how well his spontaneous restorative capacities can heal the damage that they do. Nevertheless we are surely justified in acting on the principle that prevention serves society better than restoration and perhaps carries with it a measure of positive mental health. Both humanity and the need to advance our knowledge obligate us to apply even our uncertain knowledge. This is presumptive prevention.

Some persons try to carry out presumptive prevention only through education of the public. But education is only one instrumentality of prevention. Sometimes there is greater need to organize citizens who are already well informed and activate them to try to eliminate causes. Sometimes it serves a better purpose to make careful studies to determine what the offending causes are, where the conditions can be bettered, and what the obstacles to progress are. Even where education is accepted as an instrumentality rather than a goal or a program in itself, it is important to understand that its effectiveness has usually not been tested. Will it remove factors which presumably cause the trouble? Since so much of education is accepted a priori as good without showing proof of its eventual value, any challenge of education for mental health is apt to be resented. Education can be seductive if it is considered to be above challenge.

Most of the steps that are actually taken toward prevention of mental disorder stem from our understanding of the neuroses. Intensive psychotherapy, including psychoanalysis, has shown that psychoneuroses are in part the expression of psychological disturbance arising in early years and primarily within the family. Even in a predominantly organic psychosis, such as a delirium, it may be assumed that the ideas expressed are derived from the background of the patient, just as in the neurosis, not from the toxin. With in-between conditions, such as schizophrenia, the same thing may be true, and there is some indication that emotional disturbances play a role in triggering, aggravating, or perpetuating some of the organic or constitutional factors in mental disorders. Consequently the understanding of personality development and its deviations derived from detailed studies of the neurosis have broader preventive implications than for the neuroses alone.

Most preventive work at present is aimed at improving the factors that influence psychological development from birth onward and especially the interplay of emotions within the family. It aims to protect the early years of life, for it is in those years that the foundations of personality are laid and the potential for adjustment or disturbance established. But there are other environmental factors that are apt to be missed. Chapter 10 on the offender dealt with some of these. Hare[2] points out some of the subtle environmental forces that seem to contribute to mental ill-health. He refers especially to the difficulties faced by a person who is in a strange culture of which he has not become a real enough part to benefit by its help and support. Migrant or transient people are thus especially vulnerable, until like the gypsy they have evolved a viable culture of their own. Changing to a new host culture, therefore, constitutes a mental hazard, and the "stranger that dwelleth with you" offers an opportunity for prevention. Isolation in a rural area or the loss of identity in the routines of industry involves this same hazard. Society is vaguely aware of the hazard of cultural dislocation, as shown by its quips about the morals of sailors and traveling salesmen.

Well-focused efforts at prevention call for a clear appreciation of the meaning behind such terms as mental disorder, mental disease, or mental illness. These are really plural terms covering a group of diseases. One can try to prevent a mental disorder intelligently only by specifying a particular mental disorder. To speak of mental illness as *a* disease is as incorrect as to speak of febrile illness as *a* disease. Any disease is a breakdown of balance and control. Fever is a breakdown in the thermostatic balance. Mental disease is the breakdown in the channel of understanding and effective relations with the surrounding world. This breakdown may result from a great variety of causes, only some of which are subject to control in the interest of prevention. There is growing evidence that delirium tremens is the result of a breakdown of balance occurring when alcohol, to which the body has become accustomed, is withdrawn. Just as the infectious process resulting in fever may end with a new bodily balance—immunity—which guards against recurrence, so in the case of some emotional disturbance a new homeostasis (recovery) may be achieved and serve as a protection against a future disturbance from the same cause. But at the other extreme both fever and mental disorder may be fatal.

While the factors that must be controlled in order to prevent mental illness are discovered by scientific case studies, these studies must be broad enough so that important factors are not missed. This calls for research by a variety of scientific disciplines. To expect one scientist to be complete in perspective is to ignore the vast amount of knowledge about human behavior derived from anthropology, sociology, psychology, physiology, and the applied sciences. The patient is continuously offering leads to prevention through his complaints, interviews, history, and other examinations. If these leads are to be recognized and understood, there must be a multidisciplinary research team broader even than now exists.

Relative Prevention and the Prevention of Relapse. The first two forms of prevention—absolute and presumptive—are essentially the tasks of public health and its collaborating fields. The two other forms of prevention—relative prevention and the prevention of relapse—are the tasks of those who treat the sick. Relative prevention merely tackles the problem early to forestall its becoming worse. Prevention of relapse is a continuation of the therapeutic task into the period of convalescence and recovery.

PREVENTIVE ROLE OF PUBLIC HEALTH

Since real prevention is directed toward those who are as yet without mental disorder, the social institutions through which it is carried out are chiefly those which are concerned with normal persons. These include public health, the school, the church, recreation, work, and the home. In this chapter the role of public health is considered. Later chapters will discuss the preventive work of the other fields.

Past Work. Public health agencies have already been effective in the prevention of mental disorder. They are to be credited with having decreased general paresis. In New York this illness has fallen from 8.2 per 100,000 population in 1911 to 2.8 in 1950. But this result has been incidental—and properly so—to the interest of public health in controlling venereal diseases. There has not been a strong specific concern for general paresis and other mental disorders.

However, in spite of some strong encouragement from within the public health field, especially at Yale and Johns Hopkins and at several of the larger foundations, public health officials have been slow to take the initiative in developing their potentialities for mental hygiene. Even though schools of public health have added mental health to their curricula, it is too often not sufficiently designed to develop the skill for meeting the everyday tasks of public health but is simply a set of lectures in psychiatry as given in medical schools. So much of public health work is based upon well-validated scientific procedures that mental hygiene appeared to public health officers as relatively undeveloped scientifically, as in fact it is. It does not offer the kinds of opportunity for control that water-borne diseases offer. In other words, they have stood hand in hand with the general physician in a kind of scientific aloofness toward mental illness. Public health and medicine however, have themselves suffered from this attitude. Many of their failures can be accounted for only by understanding human behavior. Boudreau, in fact, as late as 1953 found it necessary to chide the public health officer and refer to mental health as a new frontier as follows:[3]

> Public interest in the subject and public demand that something be done about it, bring the responsibility squarely up to practitioners of public health and medicine, the appointed guardians of the health of the people. Such practitioners may shrink from mothering this infant which the public has dumped on its doorstep, but it is not the first time that public pressure has broken through the barriers of professional hesitation and misgiving.

There are still too few public health personnel who are trained in mental health. The National League for Nursing has fostered the inclusion of psychiatry and mental health in the basic and specialized training of nurses. It sponsored and provided scholarships for the training of mental health nurse consultants. The day-to-day mental health functions of the public health nurse must depend, however, not primarily upon special consultants but upon a fuller competence in mental health on the part of the regular supervisors. Only when the supervisor incorporates mental health practices into her work will the staff nurse be convinced that it is an essential part of her job, too. If the supervisor uses only authority in her relation with and help to patients or subordinates, she helps the patient to become dependent and the staff nurse to encourage dependence.

Visiting-nurse associations were among the earliest public health agencies to see the need to incorporate mental health into their programs. A survey of the Henry Street Visiting Nurse Service made by the National Association for Mental Health in 1927–1928[4] led to the addition of a mental hygiene consultant to the staff of that agency. Other public health nursing agencies similarly broadened their work, and the National Organization for Public Health Nursing added a staff member to aid in this development. These consultants helped the nurse to deal with emotional problems, to detect mental problems earlier, to guide parents, and to prepare patients for psychiatric consultation.

Except for a few states, such as Connecticut, the state health departments prior to the end of World War II gave little attention to mental health. A few received encouragement from several large foundations, and some got help from the U.S. Public Health Service. Lemkau[5] finds some five with mental hygiene components worthy of reference. Still even in most of these the work was spotty and thin. Mental health activity by public health agencies suffered during the war, because it was a function of a low priority that could be dropped in times of stringency and terminate when private grants ceased.

Prospects. The experience of public health has much to offer in developing mental hygiene and advancing psychiatry. Its epidemiological perspective and technique are especially valuable and should be incorporated into the training of psychiatrists, psychologists, and social workers. Safeguarding the mental health of a community can begin with experts, but it cannot be left in their hands. Every agency is a potential partner in the task and must be drawn in by public health–minded experts who are dealing with the mentally ill. Physicians are better mental hygienists if they understand these public health essentials, too, as also are the police, the family service and other welfare agencies, the churches, the county agricultural agents, and the schools. Public health nurses form a potential first line of defense against mental disorder, for they guide parents in child care when guidance is most needed. In addition, the public health officer has acquired a public respect that brings support to him and protects him against political interferences as no other public servant is protected. Public health officers have shown more interest in mental health recently since some of their traditional preoccupations, such as tuberculosis control, are becoming less pressing. They now have more freedom to seize new opportunities.

From 1940 to 1946 the National Association for Mental Health sponsored legislation to extend the preventive functions of the U.S. Public Health Service. The resultant National Mental Health Act has greatly expanded the mental health activities of state health departments. It has helped finance the training of mental health nurse consultants. It has made grants for research projects pointed toward prevention. The broad program of the mental health research center at Bethesda, Md., promises to enrich our understanding of cultural factors, heretofore neglected, that contribute to mental disorders.

Federal interest in mental health is, of course, not confined to the Public Health Service. Another program is carried out through the extension work of the U.S. Department of Agriculture. This work helps the states to carry on a program of home economics, child development, and nutrition. It has played a part in the eradication of pellagra. Another form of Federal grant helps local health departments to provide health services for children. This program is administered by the U.S. Children's Bureau. While it is a general health program, the Bureau has encouraged the inclusion of mental health work. The services to expectant mothers and to well babies and the training of health workers under this program have special bearing on mental health. Many of the activities of the U.S. Office of Education are also directed toward mental health.

Not infrequently there is competition between the state department of health and the department administering the state mental hospitals for the right to administer clinics. It is quite understandable that in many states the department of health should feel superior scientifically to the state psychiatric service, for in fact they are supported and operated at a scientifically higher level. But, as was pointed out in Chapter 4, the outpatient and inpatient psychiatric services are interdependent, and state psychiatric authorities need very much to carry the full treatment task in order to overcome isolation and improve quality of service. The clientele of preventive work differs from that of treatment. The restoration of mental health is concerned with the sick. Prevention is concerned with the whole population and especially those who are living in mentally hazardous situations. As with other forms of illness, these hazardous situations are made evident by the histories and examinations of those who have fallen ill and should be reported to preventive authorities. But sometimes public health agencies, instead of trying to eradicate hazards, concern themselves only with relative prevention, i.e., the conduct of clinics for diagnosis and treatment. These clinics are not needed, as they are for example in the case of venereal disease, chiefly as instrumentalities of more general control. Not only is the peculiar opportunity of the health agency thus neglected, but the public psychiatric services (hospitals) are deprived of this important antidote to isolation. Instead of competition there is need for designed interagency collaboration between the corresponding private and governmental authorities which are concerned with prevention and treatment. Health and welfare councils are one instrumentality for fostering this teamwork.

MENTAL HEALTH IN PUBLIC HEALTH

Mental health is a concern of public health in practically every phase of its work. First, in its traditional function of disease prevention and control, the sciences of human behavior facilitate and expedite the application of its specific knowledge of disease. The obstructive attitudes of the public and professions are often the most serious deterrents to progress. Second, in the prevention and control of mental illness, the sciences of human behavior themselves have become specific and basic. Third, in more peripheral or contingent functions of providing medical service, public health is confronted with the same mental health problems as is the practice of general medicine.

Disease Control. During the first half of the twentieth century the common functions of public health became better defined so that from place to place there was a consistent core of functions. This core included the control of communicable disease, the control of nutritional deficiencies, and the control of insect-borne diseases. For the control of some of these diseases the point of attack is well known and the techniques well developed. Yet some of these diseases persist. The obstacle is the human factor. It depends upon ignorance and resistant attitudes, both problems of mental health. The control of syphilis is a case in point. Again and again prevention is blocked by attitudes that interfere with the discovery and treatment of focal cases. The obstacles to public health are often deeply rooted psychological habits. If these habits are to be altered, sociology and anthropology have much to contribute. This fact was appreciated by the Federal government when during World War II it delegated a cultural anthropologist, the late Dr. Ruth Benedict, to collect information on the food habits of central European countries. This was to serve as a guide in feeding these countries when they were liberated. But the psychological habits that obstruct public health are not confined to the unschooled. The medical profession itself has often been most resistant to new public health advances. The inseparability of mental health and public health is well described by Ginsburg.[6]

One of the frontiers in the public health field is the development of techniques for mass screening. Mass screening is not a diagnostic procedure. It is only an alert to possible trouble. X-ray techniques have proved highly valuable for chest diseases. But mass-screening techniques for spotting danger signals of mental ill-health are hardly developed at all. Even if they were, their application would depend to a great extent on motivating people to submit to mass screening. Studies of the motivating and deterring forces that encourage or obstruct cooperation and participation are sorely needed. There is need also for good herding techniques for those who can be screened. The report of an interesting experiment in the use of multitests [7] shows how limited the techniques are at present for mental health screening and at the same time how success depends on the attitudes of the doctors and the subjects.

The Pan American Sanitary Bureau, which serves as the regional office of the World Health Organization, conducts very extensive public health programs throughout the Americas. Few of these programs are overtly occupied with mental health. Yet the success of many of the projects, especially those bearing on maternal and child health, will depend upon the psychological techniques of interviewing and the analysis of motivation. The World Health Organization does better; it has mental health personnel on its staff. This personnel is especially helpful in diverse public health activities which in themselves are not concerned with the prevention or control of mental illness.

Jensen [8] believes that public health will experience constantly diminishing returns unless new elements are added to present techniques. He believes more attention will have to be given to the way people think and feel and the way they live in their communities. He feels that public health will broaden its influence and advance mental health when it replaces enforcement by authority with enforcement by motivation. Hiscock [9] sees the prevention of mental illness as a new trend in public health.

But the public health officer does not function in a vacuum, nor does he have control over the schools, the police, and many other functionaries and conditions that influence mental health. His success in protecting mental health depends, therefore, on his capacity to enlist the cooperation of other community agencies. In this respect it is of interest that, early in the formalization of the body of knowledge of public health, poverty as well as specific diseases was identified as a concern of public health.

It is inevitable that as a discipline grows and expands it comes into contact with other disciplines and closes the gap between them. It then more truly coincides with the integration of those whom they serve. But opposed to this is a common tendency for a discipline to claim as its own territory all the areas into which its work may lead it. This omnibus tendency produces conflict, noncollaboration, and isolation. Only the ability to find vicarious satisfaction in the achievements of other disciplines in which one has a small hand can prevent this parochialism.

The need for collaboration includes not only public but specialized voluntary citizens' organizations which are concerned with some of the factors leading to mental ill-health. The American Social Hygiene Association is concerned with the eradication of venereal disease as well as the strengthening of family life. The National Committee on Alcoholism [10] tries to keep the use of alcohol within the bounds of reason. Brain tumors are a part of the concern of the American Cancer Society. Brain injuries come within the interests of the National Safety Council. All these citizen organizations are involved in the prevention of mental disorders.

The efforts of health agencies to prevent mental illness have already been discussed. As a part of their interest in mental health some health departments carry on a vigorous program for the prevention of alcoholism. This is basically a mental health task, for it requires control of the psychological forces that make people overindulge. Up to the present these psychological factors have been revealed chiefly by psychiatric research. But there are growing indications that metabolic and endocrine factors may also be involved.

Medical Service. Medical service is not a constant function of public health. Some states and communities combine public health and medical services into one department. Some keep them separate. Some leaders in the public health field do not welcome the combination, since the budget of medical services is so great that it may overshadow essential public health work. Also they see danger in that the combined services may be directed by a therapeutically oriented physician rather than a public health expert. On the other hand, some favor the combination as an opportunity for greater integration or simply an expansion of authority. Of course, the difference between public health and medicine is not clear-cut. In the control of certain communicable diseases, medical service must be rendered inseparably from prevention in order to eradicate the foci of spread. But neither can any two fields that deal with human problems and needs be independent of each other and still do their best work.

The combination of public health and public psychiatry highlights all the problems of joint medical and health services. The budgets of public psychiatric services are tremendous but still too lean to support the scientific standard to which public health is accustomed. The official combination also obscures the need for functional collaboration that goes beyond these two. A spokesman for one such combined department revealed this in saying, "We have included all the mental health functions into one department." Since he did not realize that other departments, such as education, carry important mental health responsibilities, he had taken no steps toward collaboration. Omnibus agencies fail to see that the omnibus is never complete. The combination of public health and psychiatric services is the rule in Canadian provinces, but the exception in the states.

There are other compelling reasons for close collaboration between public health and public psychiatry. The patients in state mental hospitals are subject to all the health hazards that beset the community. The hazards are furthermore heightened by the very inability of the mentally ill to regulate their lives and by overcrowding and shortages of staff. The incidence of tuberculosis, intestinal infections, and infestation is high. Public health departments are of great help in many states in detecting foci of spread and in keeping these hazards under control. Of course, the control of communicable disease in the mental hospitals reduces its spread to the community.

Clinical psychiatry has in turn contributed measurably to public health. It has identified factors in the mother-child relation that affect the child's whole development and that are subject to some control. The techniques of scientific interviewing have been analyzed and developed to a point where they can become an effective tool in public health. It is no longer necessary for the public health nurse to rely solely on intuition to guide her to an understanding of the psychological interplay between her and a patient. Nor must the public health officer proceed entirely blindly in searching for the motives of a resistant citizen. Motivation can, therefore, be applied more designedly. Anxiety is better understood, and ways of dealing with it are put on a practical basis.

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PART FOUR

Elevation of Mental Health

16 POSITIVE MENTAL HEALTH

The World Health Organization has defined health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity."

The mental health field encompasses three sets of objectives. One of these has to do with mentally sick persons. For them the objective is the restoration of health. A second has to do with those people who are mentally healthy but who may become ill if they are not protected from conditions that are generally conducive to mental illness or conditions to which they as individuals are especially susceptible. The objective for those persons is prevention. This was the subject of the preceding chapter. The third objective has to do with the upbuilding of mental health of normal persons, quite apart from any question of disease or infirmity. This is positive mental health.

CONCEPT OF POSITIVE MENTAL HEALTH

Positive mental health is based on the recognition that all persons have potentialities or talents, sometimes very modest and sometimes great, that may either be allowed to languish or, at the other extreme, may be developed to their fullest. It is these abilities cultivated to a higher level that constitute positive mental health. Positive mental health accordingly results in a higher level of performance and satisfaction. As expressed by Dr. Leonard Scheele,[1] Surgeon General of the Public Health Service, "The goal is not merely to extend life but to augment its power." One might say that positive mental health means more robust, broader, and more productive living. Its counterpart, positive physical health, means greater power in the tissues and organs or parts of the body. The muscular development and skill of the athlete is a case of positive health.

If positive mental health is evaluated by the application of the six criteria of priority (see Chap. 2), it may be seen that the seriousness of positive mental health is measurable by the extent to which one's capacities are used. It shows up in greater productivity, richer living, increased satisfaction, and better human relations. Like prevention, positive mental health is of value to the whole population and is usually achieved by broad social measures such as racial desegregation. The social implications of positive mental health are identifiable in terms of leadership and teamwork, highly developed skill, creativeness, and other qualities that make the individual an asset to his group. The scientific foundations of positive mental health are best established in the field of education. Psychological research has produced knowledge and techniques for measuring mental capacities and nurturing them, and social psychology has revealed much about the milieu that is conducive to mental growth. In the areas of family living, recreation, and industry, the scientific development has been slower but is progressing. The public's interest in and support of positive mental health through improvements in family life, the church, the school, and recreation is extensive but overly conservative.

Positive mental health may or may not be preventive of mental disorder. By analogy it is exceptional in civilized society that great muscular development contributes to survival or freedom from illness, but in a wilder state it had such value. Positive mental health may likewise be incidentally preventive, particularly in a world of psychological warfare, but as a concept it is not directed toward the susceptibility to disease. In fact in the case of the mentally sick certain powers are apt to be preserved whose development can still be enhanced. That is, the processes of positive mental health are not inapplicable to the mentally ill.

Some people find it hard to distinguish positive mental health from prevention. The difficulty may depend on one's professional orientation. The teacher is occupied, day in and day out, with children who are mostly normal and whose potentialities he is assessing and fostering. All aspects of living are seen by him in terms of their bearing on normal growth. He readily grasps the concept of positive mental health. A pupil may fall ill, but illness is not the teacher's main concern. In fact he too often fails to recognize mental ill-health. The physician, on the other hand, is focused on illness. All aspects of his professional life are seen in these terms. It may be hard for him to encompass the idea of positive health.

Often he speaks in favor of positive health only as a protection against noxious influences.

BASES OF POSITIVE MENTAL HEALTH

In Chapter 1 the manifestations of mental health were described as variable, resulting in quite different behavior under different conditions. But in general it is reflected by the way a person relates to his environment. It is quite evident that the capacity to harmonize with one's environment and to be a part of a social group is more highly developed in some persons than in others. But since one's relation to his environment is to a great extent a reflection of his feelings about himself, any effort to help him to realize his potentialities must begin with the development of wholesome feelings about himself. The forces that make for this development are found first and most strongly within the family.

People vary all the way from idiot to genius in the extent to which their potentialities—capacities for thinking, feeling, and acting—can be developed. Those occupied with positive mental health are therefore interested in factors which produce this variation. A knowledge of these factors helps them to set realistic goals and to plan individually for those whom they hope to serve. These factors are of two sorts:

1. Individual factors. Each person has his basic peculiarities, his strengths and weaknesses, and his potentialities for development. Some of these are innate, some are acquired later. He is what Dr. Adolf Meyer called an experiment of nature in that he is composed differently from anyone else. There is a wide range of such individual differences, both qualitative and quantitative. Intelligence is an example.

2. Social differences. The home surroundings, neighborhood, church, education, and work through which one passes vary from person to person, and the potentialities of future experience also vary. Each person is limited by these variables.

Those who try to promote positive mental health try to help the individual to discover his potentialities, i.e., variable 1; and the most favorable conditions for the cultivation of these potentialities, i.e., variable 2. In brief, they foster positive mental health by design rather than by mere chance.

The knowledge that can be called upon to aid in the development of talents is found in the customs, laws, and attitudes among which people spend their lives. The social institutions that are especially concerned with positive mental health include the home, the neighborhood, the church, the school, and the job. There are local, state, and national laws, regulations, and financial support designed to safeguard and to advance this function. They help in the assessment and use of both individual and social components of mental health.

FOSTERING POSITIVE MENTAL HEALTH

The individual component of positive mental health is violated whenever and to the extent that averages or single standards of any sort replace individualization. This individualization, however, need not require a completely different plan for each person but rather a range of alternate opportunities from which he can choose according to his interests. Most persons can adjust without strain to a certain amount of planning for them by others or departure from strict individualization.

In some instances where talents are unusual they have to be actually identified in order to provide for their development, since the resources needed may not be common enough to be at hand or readily accessible. In other instances where the resources of the community are varied, or where the talents are more common, the mere availability of resources to aid in the cultivation of talents may be enough to ensure their spontaneous use. In that case talents may grow of their own momentum without ever having been formally identified and planned for. The effort to develop positive mental health assumes that there are capacities which will come into use when the right opportunities are made available, provided adverse experiences have not suppressed them. Facilities set up to foster positive mental health should be flexible and permissive enough to allow the individual to shape them to meet his needs, but sometimes their use has to be encouraged, controlled, and directed, for there are some persons who are unable to get into action without direction.

The evidences of wasted mental potentialities are all about us. These signs need to be heeded if positive mental health is to be advanced. Individual talents, individual experiences, and individual differences are often not identified at all by even the person himself, or, if identified, are ignored or suppressed. Often a deliberate compromise between individual and social demands must be made for the sake of the greatest realization of the individual both for himself and for society. The climate of love and respect which is conducive to the optimal expression and development of individual potentialities is too often so absent in the home, school, and industry that the freedom to follow one's bent is hampered. On the other hand, freedom needs a background of security based on fairly well-defined social standards and a definition of the limits to freedom.

The incentive for one to develop positive mental health lies in the satisfactions he gains by using his potentialities. This incentive can in turn grow stronger, for the use of a talent increases and refines it, so that it affords in return an even higher level of satisfaction and incentive.

The need for flexibility in the cultivation of potentialities stems from a distinctly human characteristic. Compared with other creatures, man is less dependent upon instincts for his behavior and survival. Instead he very early learns his behavior from his family and neighborhood. They guide him into the customs of their particular society. He is in the beginning more fluid psychologically than other creatures and has a capacity for the development of a wider range of habits. Conversely his development may be disabling if his habits are guided in a direction that is not suited to his individuality and that of his milieu.

It is all too easy to misdirect talents, skills, ambitions, and values if the person or agency that is trying to encourage their growth is not in tune with the times and place. It takes wisdom, security, perspective, flexibility, and a capacity to love and respect others to guide talents wisely. Too often the one who is trying to help adopts himself as the model rather than using as a guide the full potential of the one who is being "helped." This is a special hazard where the cultures of the two differ radically. A person who values future achievements above all else must be aware of his limitations when he is guiding one in whose culture *today* gives the fullest satisfaction of living.

Positive mental health may be advanced more successfully by recognizing that there is a right *time* for experiences to be made available and also a right *tempo* for growth. There are times when growth may be quickened or turned into new directions or stalled. Emotional threats tend to stall it, whereas security, love, respect, and a wise sense of timing tend to advance the realization of talents.

Respect for the individual is more than a polite bow. It means that he is allowed to guide his own life as fully as he can, that he is not forced beyond his limits, and that he is treated as a well-organized whole and not confused by subjection to conflicting assistance. Too often the agencies of the community which are set up to foster mental health fail to ensure to their beneficiaries that their offerings are harmonized. Respect means that his peculiarities will be accepted as a foundation for development rather than as abnormalities to be leveled. When his growth has been facilitated by parents, teachers, pastors, and employers who respect his differences, he is better prepared to offer his help to others in fostering their mental health and less in danger of constricting them. In a sense only such a person is prepared to shape others in his own image, for the essence of his image is the acceptance of difference and the fostering of growth.

Just as the treatment of mental deviations and the prevention of mental ill-health are the concern of well-established social institutions, so also is the fostering of positive mental health. It is through progress in these institutions that mental health is advanced. Any effort to advance positive mental health must strive to bring about such progress. These social institutions are the subject of the next six chapters. All of them are oriented toward positive mental health and deal chiefly with relatively normal people. All of them encounter mental illness incidentally in the course of their work. These agencies include the home, the church, the school, the agencies of defense, industry, and recreation.

NOTES

1. Scheele, Leonard A.: *The Orientation of Public Health,* Public Health Service Publication 436, Washington, D.C., 1955.

17 THE HOME AND FAMILY

It has been emphasized again and again in previous chapters that psychological feelings—emotions—reflect mental health. The same emphasis will be found in the chapters that follow. While emotions are of fundamental significance, it is futile to try to determine whether they play a greater or lesser role than the thinking or intellectual aspect of living, for there are no common units of measurement that permit such a comparison. Furthermore, there is no valid separation of the two. Still man likes to think of himself as rational and so pays more respect to his logic than to his feelings. The feeling aspects are often suppressed, ignored, and wrongly valued. They are often unrecognized because they are apt to be subtle. The atmosphere of the classroom, the spiritual element of the church, the faith in the doctor, the aversion to a mental hospital are all expressions of feeling and are not easy to capture and describe. The neurosis and many talents are continuances or relics of feelings which began very often when words and logical relationships were still unformed in infancy.

THE ROLE OF THE FAMILY

The family is the social capsule in which feelings develop, and therefore it becomes the most potent force in shaping the mental health of everyone. The revelation of the subtlety, complexity, and elusiveness of the psychological forces in the family which affect the child's feelings and attitudes are a special contribution of psychoanalytic research. The changes of styles in the rearing of children reflect this complexity, but they also reveal the belief that it is important to think as well as feel about child rearing. The search for proper methods reflects distrust of intuitive procedures because so many mistakes seem to have been made under the guidance of intuition. Perhaps it is the instability of our culture that makes intuition such a risky guide.

One serious interference with the feeling element of family life has been the widespread abandonment of breast feeding. This was abetted by the mother's distrust of her intuitions. Breast feeding, which helps establish her feeling-relationship with the child, strengthens her intuitions and provides the child with a sound basis for his emotional growth. Too often the physician appeases the mother's anxiety by encouraging artificial feeding without understanding the psychological consequences. Both mother and doctor need to understand that the family is a proving ground for feelings and that the mental health of the child and mother may be jeopardized if their affective life is pauperized.

The goal of the family is, of course, not limited to the rearing of children. It provides emotional support to all its members. Especially is the support of the family needed when aging and widowing destroys supports that have served over a long period of years. The malfunctioning family which has lost its ability to cultivate the feeling side of life may still hold together physically due to religious, economic, cultural, and emotional forces. However, disorders of behavior among its members betray its failure. One who has grown up in a family in which affection is lacking finds it harder to be a wisely affectionate parent and in turn handicaps his own children. Thus mental ill-health begets mental ill-health in such forms as neurosis and delinquency. For this reason the child-guidance clinic commonly focuses its efforts upon the family dysfunction rather than working exclusively with the child.

A liberal and mentally healthy family is a good school for a democratic society. Many of the threats to democracy, such as authoritarianism, power, domination, intolerance of difference, and excessive demand for security are impoverishments of mental health if not actual ill-health.

Plant [1] has very well outlined the role of a family in a democracy. He lists the dangers from which the family may protect the child:

1. "Lack of belongingness." Where this is weak within the family, it is apt to be weak within the political structure.

2. "Frustration in growth." As the family protects the child from destructive frustration, it helps him to grow emotionally. A family that is not afraid of the child's evil potential gives him opportunity to try out the good. Democracy thrives on emotional maturity.

3. "Fear of change." A child naturally hesitates in the face of change,

but the family can meliorate this by controlling the rate of change. Change is rewarding, for unless democracy changes it regresses.

4. "Mistaking symbols for reality." A complex society develops many symbols to help it to function, e.g., grades and promotions. Sometimes these are assigned value in themselves and dominate the relationship between the child and his family.

5. "Sense of personal futility." Many citizens believe they can do nothing to improve government. A domineering parent fosters this attitude.

6. "False idea of freedom." Parents who martyr themselves for their children handicap them for life in a democratic society.

Plant then goes on to the positive aspects of development and lists tolerance, leadership, capacity for defining values, capacity for growth and conformity to law as products of a good family.

Thirteen years later Frank[2] again emphasized the relation between mental health and democratic living:

> . . . democracy is more than freedom of action, speech and beliefs precious as these are. . . . Democracy is essentially an expression of faith in human beings, a belief in self-correcting, self-repairing social order which people must strive for in all their living . . . responsible self-disciplined conduct by healthy personalities. . . . A democratic society cannot permit anyone . . . to be unnecessarily deprived, frustrated or denied, to be stunted, warped, injured, humiliated . . . because we know . . . that anyone so treated will be incapable of developing as a healthy personality or of . . . conduct and relationships that are essential to a free society.

These qualities emerge from the family.

Cultural Role of Family. Unlike any other animal, man is insufficiently endowed at birth with instincts to ensure survival. Instead of instincts he develops a set of customs which help the family and community to serve him from birth to death. These customs are extremely varied from people to people, but in any case they are matters of life and death, for when they are disturbed the result may be disabling or fatal. The members of a family strongly resist efforts to change its customs. In fact, outsiders whose customs differ may be resented as a threat, as if the rightness of one set of customs negated the rightness of all others. By this principle many persons cannot be comfortable in the face of any kind of difference.

Perhaps the most important psychological function of the family is to provide the child with a culture which will serve his own life needs and at the same time make him acceptable to the social group in which he will live. Where the culture of the family is compatible with that of the social group in which he lives, the child will usually fit into that group. The child learns the customs of his group, not formally but by innumerable examples of the values and behavior that the group favors. The parents are only partially aware that they are teaching.

On the other hand, neither families nor social groups expect absolute conformity of their members. This leniency helps in making an adjustment to strange social customs. In fact a premium is placed on some degree of variation from the standard of the culture. With the help of this sanction differing talents are permitted to develop, marital partners are enabled to accept each other, and mental health is furthered.

THE AILING FAMILY

The evidence of difficulty in finding a sufficiently binding community of interest in marriage is found in the divorce rate. Buell[3] has called attention to the inordinate number of social problems that stem from certain families. He suggests that the crucial factor in this phenomenon is the discordant emotional problems of the marital pair. He suggests that it may have been these common problems which drew them together in the beginning. But, as has been pointed out by Ackerman,[4] the binding force that preserves a family may sometimes consist of complementary rather than similar neuroses in the partners. Some families thrive because the peculiarities of one partner are balanced by equal but opposite deviations in the other. In fact the family may break up if the deviation of one is reduced. On the other hand, these complementary partners may make fine parents as well as companions. One may hope for the development of a family science that can foretell how better families may issue from a fuller understanding of the deviations and the assets of the marital partners. In this way the family may be further refined as an agency of positive mental health in an unstable and changing world.

The predicament of the family which includes an adopted child or stepchild may be somewhat more difficult than that of one in which the members have grown up together. The latecomer has a past experience and certain loyalties which cannot be shared by the others and vice versa.

One might expect on theoretical grounds that the home in which there is only one parent and in which compromise between parents is unnecessary would put less pressure on the growing child. About 12% of children live in such a family. A family consisting of one parent and offspring has, however, a special handicap. Such a family might be thought of as psychologically parthenogenetic or inbred and accordingly lacking in the positive values that come from difference. Even if its members are spared all parental conflict, they live in a society whose pattern of life is different from the customs outside the family. Also few such parents can be at ease in single blessedness. The unwed mother is so often the product of a home that was lacking in affection that she also has difficulty giving affection in suitable measure. Still such a home, in spite of its deficiencies, is probably more conducive to mental health and later adjustment than an asylum in which the child is treated impersonally.

But accidents may happen to a culture which arouse anxiety and confusion, even though they often eventuate in enriched living. In the past half-century, conditions of living involving food, clothes, housing, lighting, heating, traveling, and even language have changed so rapidly that people cannot depend as much as formerly upon customs to guide them. When such changes take place within a generation, customs for dealing with them cannot be firmly established in a family or group. Under these conditions the child who is learning his ways of life from those about him senses discrepancies and must work out his own compromises. He cannot be taught time-tested, ready-made patterns. His compromises are to a degree blind fumblings, which may be helpful or harmful as detailed in Chapter 10. It is not surprising, therefore, that parents should begin to distrust their own intuitions, which they still cannot abandon. No wonder they seek outside help in rearing their children.

Such changes are increased as communication and transportation are made easier. Marriage requires adjustments and compromises even if the cultures of the pair are essentially the same. But where their cultures are more divergent, the adjustments become more difficult. When these adjustments are successful the potentialities for living are broadened.

The conditions which disturb cultures are spreading rapidly over the globe. The promotion and protection of mental health, therefore, acquire a new significance, and especially is this true of that aspect of mental health that permits one to be comfortable with, even give high value to, differences between people. A family composed of parents of very different backgrounds may still serve its role well and nurture the talents of its members if the parents are mentally healthy to the point of finding positive values in their differences.

HELPING THE FAMILY

Perhaps families need to be helped to a greater awareness of the changes that are taking place in family life, the difficulties that result, and the ways in which they may compensate for these changes. Some experts are advocating more whole-family activities. Since the role of the father in the family is especially disturbed by his absence while at work, his participation in such activities is especially encouraged. For many families the church stands as a common interest. In any case few families are aware of what is happening or skilled enough to do something about it. The understanding and initiative will have to come from community agencies equipped to give help.

Communities are increasingly aware of the importance of family life and plan their health education and welfare agencies so as to help families to be more successful. Many agencies keep their records and plan their services on a family rather than an individual basis. The professions that serve people personally are also coming to appreciate the bearing of family functioning upon their work. There is a growing body of scientific knowledge about the family, and there is more interchange between the practicing disciplines and sociology, psychology, home economics, and anthropology. The National Council on Family Relations[5] serves as a medium of exchange and a common forum for these groups. The White House Conferences, which under the impetus of the U.S. Children's Bureau are held every decade, provide an opportunity for periodic evaluation and a springboard for action in the succeeding years. At a 1954 meeting of the Conference on Children and Youth (a continuance of the 1950 White House Conference) the mental health section stressed particularly the coordination of all agencies serving parents and children. The breadth of mental health forces is implied in the list of these agencies. It includes obstetricians, pediatricians, family physicians, public health nurses, hospital nurses, child welfare and family service workers, teachers, psychiatrists, ministers, psychologists, police, judges, and recreation workers. These are all able to help the family to be more successful.

Family Counseling. The earlier tendency to blame parents when the family fails is giving way to the recognition that parents, too, are victims of circumstances and are only further disorganized by a criticism that is unaccompanied by help. It is perhaps inevitable in these early days of family science that there should be conflicting theories, varying advice, and confusion. Even such a state of affairs offers more promise than a single prematurely accepted theory.

Marriage counseling has grown steadily in recent years. The great variety of technical questions that may be raised about family living makes it necessary for marriage counseling to become a part of the duties of all those professions listed above. However, some practitioners within these fields make marital counseling their chief concern and become exceptionally expert. But the expertness is only partly founded upon scientific knowledge. To a great extent it is an art growing out of cumulated experience. Experience, however, differs, as do social values that are certain to be infused into counseling. Confusion of the client is inevitable if these differences are imposed upon him in the course of counseling or parent education. An increasing number of persons are devoting themselves fully to marital counseling. They keep the family function from being fragmented and at the same time mobilize the best that science has to offer by enlisting the participation of different specialists according to the need. Most people whose marriage is in danger do not know of any specialist in this problem to whom to go for help. They may go to a wise person who has been helpful before—perhaps for some quite different need. They may go to a specialist such as a lawyer, doctor, or clergyman because the marital problem may show up as a legal, medical, or moral problem. Still these professions, as a rule, have little or no preparation to give help. They are also apt to see the problems only in terms of the special part of living with which they are identified. They are seldom prepared to anticipate the subtle elements which arise and which the marriage counselor and family case worker have come to expect and understand. Mace[6] identifies the services that go into marriage counseling as help with tensions that grow out of the situation in which the person is living, help in achieving a higher level of physical health, help in resolving hidden psychological problems, and help in self-understanding.

The marriage counselor would seem to be especially concerned with the third and fourth of these functions. That counseling is not the prerogative of any one profession is evidenced by the diversity of the membership of the American Association of Marriage Counselors. Mace suggests that marriage counselors should be trained in general counseling skills, of character and temperament suited to handling partners in conflict and trained for this, and equipped with a sound and wide general scientific knowledge about marriage.

PARENT EDUCATION AND THE NURSERY SCHOOL

Many colleges and public schools are providing premarital courses for their students. Several universities maintain research and training centers devoted to child growth and development. These centers have contributed greatly to our body of knowledge about the positive mental health functions of the family and methods of parent education. In the field of parent education the Child Study Association of America [7] has a long record of practical experience and has contributed both materials and methods of parent education. Associations of parents and teachers and many women's organizations make child study a major part of their programs.

Since the success of parenthood depends so much upon the atmosphere of the home and upon the feelings and attitudes of the parents, it is generally conceded that group discussions in which parents talk about their problems and exchange thoughts with others are especially effective. They help parents to grasp the emotional side of a problem and ways of dealing with it. The expectant parent anticipating the first child is an especially appropriate and often ready subject for parent education, the more so when he is unsure whether he can meet the challenge that lies ahead. This fact has been used to advantage by the Louisiana Society for Mental Health, which sends prospective parents each month a timely letter on mental health matters of importance to that period of the child's development, continuing these letters up until the baby's first birthday. This form of education has been adopted in many other places.

Nursery School. The advancement of parent education has been paralleled by and often closely associated with the development of the nursery school, but the nursery school is still available to relatively few children. In some communities nursery schools have been provided and financed by families as a cooperative measure. At times they operate under the sponsorship of the public school system. Some health centers also include nursery schools or day nurseries among their services. A few nursery schools are really laboratories in child development, such as that connected with the University of Minnesota. These centers have contributed greatly to our understanding of the mental health of children. Their researches have established more accurate and flexible standards. They have produced educational materials and techniques which are used widely in parent education. The Society for Research in Child Development has served as a scientific forum, and its publications serve as media of communication from the research centers to the professions that are concerned with child development.

The impact of the nursery school has also brought about changes in the day nursery, which is essentially a temporary haven for the child during the absence of his mother, e.g., at work. In fact, there are all gradations now between the nursery and the nursery school.

The nursery school has special significance for mental health in that it introduces into the life of the child variations of culture at a time when the child's own cultural patterns are already partially shaped but not fixed. Prior to entering nursery school the child has lived almost exclusively wtihin the cultural pattern of his family. This mingling of patterns at an early age can be confusing to the child if both the family and the nursery school are not aware of the adjustments which the child has to make. On the other hand, the nursery school can foster that comfortable appreciation of difference which is so essential to mental health.

GENERAL INFLUENCES ON THE FAMILY

Among the agencies of the Federal government the Children's Bureau of the Department of Health, Education and Welfare, and the Extension Service of the U.S. Department of Agriculture have been of great value in bringing the advances in child development to the whole country.

The law and the courts which interpret the law are not generally regarded as positive forces in promoting mental health in the family, and all too often this view is justified. Both the law and the court are so often involved in an adversary procedure in which the judgment goes to one side or the other that they are not expected to solve problems by sociological and psychological means. Furthermore a constructive solution to many problems is blocked by the splitting up of a case among many jurisdictions so that it can never be handled as a whole. One proposal to overcome this handicap is the creation of social-problem courts. The report of a study in New York City [8] described the need, suggested a solution, and explained its implications for mental health in detail. It points out that

> . . . jurisdictional fragmentation and overlapping exists among courts which deal with child, youth and family problems. . . . The pervading idea is that a "socialized" court does not primarily seek a punitive decision which may be applied to the party at fault, but centers its attention on finding a comprehensive

solution applicable to all parties involved in a case. . . . The whole situation is examined by the typical "socialized" court with the aim of arriving at a constructive solution without thought of retributive punishment.

From the time a birth is registered, through school, through the sanction of a marriage, and on to burials and estates, the law and the court provide to the family the accumulated experience of centuries. Where the issue is clearly indicative of family failure, as in delinquency and divorce, some courts try to get away from the adversary procedure. Like the clinic, they try to help the family to resolve its problems without, or at least in advance of, formal judicial decision. The American Bar Association maintains an Interprofessional Commission on Marriage and Divorce Laws under the chairmanship of Hon. Paul W. Alexander, Judge of the Family Court Center of Toledo, Ohio. This commission includes members from pertinent scientific disciplines. It is attempting to find a better basis than the adversary procedure for settling family problems.

THE BACK-ROOM CASE

Just as other agencies for the prevention of mental illness or for positive mental health encounter and deal with cases of mental disorder incidental to their main purpose, so also does the home. Many mentally ill persons are hardly known outside the walls of their homes. They do not appear in any social institutions. The histories of many who are eventually hospitalized show that their mental disorders began years before their admission. In fact, some seldom go outside of a special room in their own homes. These are often low-grade mentally deficient who have been hidden since birth. There is little evidence of significant differences in the incidence of mental illness between the states. As against that fact there are great differences in the prevalence of recorded cases. These hidden cases undoubtedly account for a part of these differences. New York State hospitals recorded 552 cases of mental illness per 100,000 population in 1949; whereas in Tennessee there were less than 200. It may reasonably be estimated that in Tennessee, over 300 mentally ill persons per 100,000 are living in their homes. This means that the state authority which is concerned with the mentally ill has an opportunity, if not an obligation, to extend its services to these mentally ill and mentally deficient who are in their homes.

NOTES

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18 MENTAL HEALTH AND THE CHURCH

The concern of the church for mental health is inherent. This fact is often not appreciated because its concern is expressed through its own special terminology and practices rather than those of institutions more narrowly concerned with mental health. It would in fact be hard to conceive of a viable religion that did not concern itself with human aspirations and problems and the relation of these to ethics and morals. As expressed by Archbishop Patrick A. O'Boyle,[1] "Since truth is one, the valid teachings of psychiatry cannot fail to harmonize with Christian ethics." Life is full of opportunities for self-realization as well as mysteries, both of which precipitate people into quandaries. The church gives support to the bewildered and helps them to maintain a perspective in spite of the unknown. It thereby protects the effectiveness of its followers or even enhances it. It prevents these quandaries from undermining mental health. It is not surprising, then, that religion should have become as consistent a part of man as his ambitions and his ignorance of the world about him. Rabbi Harvey E. Wessel [2] also emphasizes this unifying force when he points out that "to the religious individual broadly speaking, religion represents the achievement of a satisfactory personal relationship to the conditions and circumstances of his life. Such a happy equilibrium among the forces at play within and about him might just as well express a favorable state of mental health."

RELATION OF RELIGION AND MENTAL HEALTH

It seems that it was not by chance that religion and healing were once but a single institution. Man had his problems, and religion was his sole recourse. There was no separate science, and faith was his guide to those who had knowledge and wisdom. Nor is it surprising that healing should continue to be sought by mysterious as well as by scientific means. The detachment of science from the church, in so far as it occurred, was not a complete divorcement, for science also thrived on faith. In fact, it too often had faith that its processes could remove all mystery.

While science and the church are both imbued with the same regard for the integrity of man, the possibility of their joining forces on behalf of man has been blocked by the suspicion of each that the other will fail to support this integrity. In so far as the separation did not take place, the church has sponsored, fostered, and supported scientific advance. Recent decades have in fact seen a promising *rapprochement* between science and the church. As the sciences of human behavior have advanced, religious leaders have found that the discoveries and techniques of those sciences can help them to understand and deal with the aspirations and problems of people. More and more have they joined hands with psychologists, psychiatrists, sociologists, social workers, and general physicians to mutual advantage. These professions and disciplines have been brought in as consultants and as participants in the curricula of seminaries, and clinics for mental disorders have been established in association with some churches. In return, institutions which deal with people in trouble, such as hospitals and prisons, have included the chaplain in the working team.

Ministerial and church associations such as the National Council of the Churches of Christ in the United States of America have given substantial place in their programs to matters of mental health. The National Council has a very substantial commission on health which is concerned with the advancement of the contribution of the church to mental health. The Roman Catholic Church has taken a sympathetic position with respect to many of the concepts and techniques of psychoanalysis. The modern threats to that equilibrium which Rabbi Wessel prizes so highly may have encouraged the church to seek more assiduously to apply whatever science has to offer it in understanding human needs and quandaries.

The values that people rate highly are often understood and accepted only in terms of their overt manifestations rather than their underlying spirit. Since the same value can be expressed in different ways, it may seem at times that the values differ when they really do not. The rate of social change today often forces a change in these overt manifestations and customs and leads to the fear that morals are on the wane, a fear which is in itself demoralizing. In such cases the church with its interest in values and its long perspective stands to help tide over these crises and preserve morals. It not only protects the individual from disorganization, but gives him a balance from which he may develop his positive qualities.

The impact of the church on mental health is partially reflected in the size of its membership. In the United States over 90 million of the 160 million enjoy church membership. About 47% of all adults attend church fairly regularly. Of course through the many affiliated church institutions —educational, medical, protective, etc.—the impact is still greater, and the potential for the advancement of mental health that much more extensive. The church usually has access to the homes and families of its members whether problems exist or not, and so is in a better position to exercise a positive influence for mental health than any other agency, especially in the early years of life.

MENTAL HEALTH ROLE OF THE CHURCH

The church is active in all three aspects of mental health. It is essentially an agency of positive mental health, because its major focus is on relatively healthy people. By the same token it can be a negative force—a force for ill-health—if its efforts to meet human needs and problems are not reconciled with human functioning, values, and goals and above all with human variability. Secondly, it can influence the factors that make for mental ill-health and so become a preventive force. Thirdly, it can help deal with mental deviation so as to help in its correction or make the most of residual assets.

Positive Role. The church's contribution to positive mental health grows out of its interest in the intrinsic worth of man and his aspirations. Even the least person is seen as having potentiality for development. The largest mass of the population does not consist of those who are mentally ill; rather, it consists of those who are reasonably healthy mentally but whose potentialities are unrealized. They are normal people who will go through life without serious mental casualty but with talents which are not appreciated and which are left underdeveloped. The value of the church for this group parallels that of the school, but it is differently focused. It deals with man's higher aspirations, his relation to the forces that transcend science, and his relation to his fellow man. It provides an over-all goal that may encourage aspirations that would lose meaning in the narrower range of everyday life. The clergyman tries to foster these inclinations in a way that leads to satisfaction in achievement and peace of mind. As children grow up and are restricted by the demands of the family and society, they may become blocked in pursuing some of their creative possibilities. The clergyman realizes that this is a calculated risk of growing up in society and offers understanding and a compensating acceptance and support. While from culture to culture the same church varies, still even within a culture it must be reconcilable to the many differences found within its membership if it is to meet their needs best.

Membership in the church, therefore, provides an alternate family which is unencumbered by the problems and obligations and restrictions of the natural family. There the member can find sanction for talents and interests which, though moral and ethical, may be given no support or encouragement within his family or may even meet discouragement there. If he is mentally healthy the acceptance of the church's support is not, then, a violation of loyalty to the family or integrity but a release for creativeness. The church, in short, is in a position to foster a tolerance, even an appreciation of difference, a quality that reflects a high degree of mental health. It is realized, however, that this position of the church may be resorted to by the mentally unhealthy as an escape and retreat. Nevertheless this retreat may be restorative even if not creative. Some churches have succeeded in transcending discrimination as to color and race, even in places where these prejudices prevail. In that way they help their members to do the same. This provides a release not only to those against whom prejudices are directed but to those who exhibit the prejudice, for holding a prejudice is as much of a burden on the spirit (often unconscious) as being discriminated against.

The value of the church in fostering the development and expression of worthy potentialities may seem to be limited to the periods of life when talents are being shaped into careers. But its value goes beyond that. Some persons whose main purpose, such as raising a family well, has been accomplished or who have outlived their talents are left stranded emotionally. Bodily limitations such as loss of vision or hearing, or illness or accident, have brought to a close the opportunity of others to exercise their talents. Here the church may offer a new horizon in the solace of its faith in the intrinsic worth of the person, or in that plus the resources which it can mobilize to help discover new aspirations and to develop them. If it can see the need for these services early enough its value may be entirely positive or preventive. Otherwise it may need also to restore impaired mental health.

One of the valuable resources of the church in promoting mental health is pastoral counseling. A very considerable body of knowledge has been accumulated to guide a counselor, and good pastoral counseling takes this into account. The clergyman, however, starts with certain advantages that others must create. He is presumably a good person, with no ulterior motive. His services are not usually rendered for a fee. He symbolizes faith, which is a help in establishing a positive relationship with a person in need. As a part of counseling the clergyman needs to know especially about what goes on psychologically during an interview, not only in his congregant but also in himself and between the two. A small guide to pastoral counseling, *The Ministry of Listening,*[3] reveals by its title much of the essential spirit of the interview. But to counsel effectively also means knowing when *not* to counsel but rather to refer the parishioner to a psychiatrist. And the conscientious clergyman does just that. No doubt there are elements in pastoral counseling that are different—at least in degree—from other forms of counseling. Here is a field for research. In fact, such studies have been made by the National Council of Churches.

The counseling opportunities of the church are quite broad, for in addition to general pastoral counseling they include premarital and marital counseling and youth counseling. Here the opportunities for positive mental health activities are most concentrated. The church is an accepted voice of the social conscience. It can do much to give assurance where obsession and doubt intrude on normal living. For example when the church sanctions as worthy and chaste the full expression of the sexual function between husband and wife it may do much to reduce anxiety growing out of earlier emphasis on the obscenity of this function. In addition to individual counseling the educational function of the church offers another specific opportunity for developing potentialities to the point of creative productivity.

Lag in Practice. The preceding discussion has to do with the opportunities of the church, but to a considerable extent these opportunities are not seized. Still, there are leaders within the major churches who are devoting themselves to the realization of these possibilities, and many are well prepared scientifically. The role of mental health organizations is to lend this leadership every possible support and to encourage more seminars between psychiatrists and clergymen.

Contrary to what some would like to think, the mere fact that a church is a sanctified social institution does not completely protect it from exercising a negative effect on mental health. A church in pursuit of its tenets may be unable to extend its tolerance and appreciation of difference equally freely in all directions, especially toward other faiths. The prohibitions of the church, like those of the family, may contribute to mental ill-health if they are simply imposed and not supplemented by help in making an adjustment. Many prohibitions run counter to human tendencies. There would be little need of prohibitions if this were not the case. Their enforcement, therefore, may best support mental health and avoid damage when accompanied by personal help. A strong prohibition against divorce holds down the divorce rate, but it is more effective in protecting family life and preventing disorganization and desertion when it is accompanied by more personal help such as pastoral counseling and the aid of other service agencies.

Whether the clergyman is aware of the fact or not, he is constantly influencing mental health, sometimes for the better, sometimes not. A church function that merely leaves people unhappy, afraid, or anxious, or feeling abandoned and hopeless without any help toward something better is not realizing its possibilities for enriching mental health. A sensitive adolescent who sees in church only inhibition and prohibitions can hardly look upon it as a means of liberating his undeveloped talents. If he feels that the church is no help, he may either abandon church or look for some more helpful affiliation. There is also the possibility that a clergyman may foster dependence to the point where positive mental health is blocked. Dependence may sometimes be the only alternative to mental disorder of a more serious sort. On the other hand this may simply be poor professional practice just as it is in the case of the physician who allows a patient to be unnecessarily dependent.

Preventive Role. In addition to its positive impact on mental health the church may also help to prevent mental disorders, especially those in which emotional disturbance is a major causative factor. The clergyman is available to give help weekly or oftener throughout life. But also, unlike the doctor or lawyer, he is free to approach those in trouble and offer his services without being considered overaggressive or unethical. In fact, failure to do this may be cause for criticism.

The church offers not only pastoral counseling but also consolation in case of death, sickness, disaster, and the absence of members of a family.

It offers atonement for those who are guilty of transgressions and helps in getting treatment for those who suffer merely from feelings of guilt; the clergy must, of course, know the difference. Its counseling is available from the earliest years and in all the crises of life. Visitation to those in need of emotional support brings its counsel within easy reach and facilitates the use of other community resources. Retreat and prayer are especially stabilizing to some persons who are under emotional pressure.

No man lives entirely to himself, so that when he dies the group of which he was a part must seek a new balance. If he was beloved, there is grief. The bereaved may then need help, for grief is often complicated with self-reproach for neglect or hostility toward the departed. Sometimes there are feelings of guilt over the relief that is felt if the deceased had been a burden, or over gratification at other benefits that come from his demise. Some people are inclined to suppress grief. These psychological problems are a part of the task confronting the clergyman. He can handle them merely with the assurance of good intentions, or he can bring to them also the skill of good technical preparation. In his close contact with grief the clergyman, if well prepared, may know whether the bereaved is returning to normal adjustment or is in need of psychiatric help. In the case of a death by suicide he must be aware that rational and superficial explanations for suicide may hide related problems of which he should be aware. The family may blame itself or at least feel that it is being criticized.

Churches have been active in protecting children and youth from immoral publications. There is need for scientific research to test the effectiveness of censorship, to show how bad effects of salacious publications come about, and to discover what psychological factors within the person make him susceptible to such materials.

Restorative Role. Many of the same problems—guilt, self-reproach, and anxiety—come to the families of the sick. The sick person himself also may be in a vulnerable emotional state. The physician in attendance needs, of course, to understand these problems and deal with them. But there are established functions or rites for the church to perform on these occasions which along with those of the physician help to reinstate emotional balance. Each needs to be aware of the contribution of the other. This cooperation also helps the family to participate constructively in both recovery and convalescence.

More specific than the general support given the sick by the church is formalized spiritual healing. The methods of spiritual healing vary from church to church, but their goal is the same as that of the physician. Some clergymen of scientific bent favor testing these methods for their effectiveness. Such studies are in fact under way not only to determine results but also to identify any hazards that may be involved. The importance of the church to the sick is revealed by a study [4] of the testimonies for Christian Science as published by Mrs. Mary Baker Eddy. England found that in the membership of this church nearly 80% of the men and over 96% of the women were motivated toward it by problems of health. Some of the problems of physical health were so minor as to suggest the presence of important psychological factors. This may reflect on the perspicacity of clergymen and doctors who had previously tried to help but failed to sense psychological factors.

Anxiety is particularly acute when its victim is powerless to do something about it. On the other hand, pain and anxiety may be allayed or even eliminated by action. Prayer is one form of effective action, but it serves this purpose only if based on faith. Ritual is another form of allaying action which is used by those in distress both within and outside the church. Compulsive or neurotic ritual lacks the power of a form of action that is derived from outside authority and tested by time. Religious ritual, on the other hand, has those qualities. While to the well instructed the ritual has very specific meaning, to many it is thoroughly mysterious and not the less potent therefor.

The church has been quick to recognize that the quandaries of life affect people differently and that some become ill more readily than others. It is sometimes not certain whether to demand full responsibility from the person whose behavior deviates or to treat the deviation as an illness. In any case the clergyman can render first aid pending a determination of the nature of the mental deviation. He needs to know not only what to do in such a case but what not to do. He needs to know the professional resources outside the church and how best to prepare the patient to use them. This preparation of the patient calls for real skill, for it means that the constructive relations that exist between him and the sick person must in part be transferred and shared by others who are to help him. Sometimes, on the other hand, it is the doctor who first discovers the problem and seeks the help of the clergyman in dealing with it.

Even when the mental deviation is extreme, the clergyman continues to function in team with the psychiatrist. When the patient recovers this teamwork continues, and the clergyman's knowledge of and contact with the family can help in the patient's rehabilitation. Many mental hospitals employ full-time chaplains on their staffs, since most patients are too far from home to be served by their regular religious counselors. This does not preclude the use of voluntary or salaried part-time chaplains, an arrangement which allows for fuller representation of the sects. The hospital chaplain who serves part time in a community can do much to help overcome the stigma of mental illness and reduce the isolation of the hospital. The National Council of Churches has issued a booklet, *Standards for Chaplaincy Service in Institutions.*[5]

The task of dealing with the mental patient's religious problem may be most difficult. The anxieties, delusions, and mood disturbances of patients are commonly permeated with religious preoccupations. Many patients have made the rounds of churches and doctors without relief. Some then try to develop their own religious formulations. These fail because they are an effort of despair and have not passed through the test of time and helpfulness that the established religions have survived.

It is quite common for paranoid schizophrenic patients to assume a messianic role in this vain struggle. It is thus inevitable that many of the earlier concepts of mental illness were deistic. Witchcraft and demoniacal possession seemed to explain why a relative or friend whose usual behavior was well known would in his mental illness act very differently, as if he were directed by a different personality or as if a foreign spirit or demon had taken possession of the familiar body and were managing it. Sometimes the religious delusions of the patient confirm this idea, for he interprets the unwelcome thoughts that break through from repression as not his own ideas but those of supernatural spirits. The idea of demoniacal possession persists in such expressions as "He is not himself," or "He is possessed," and in the stigma accompanying mental illness.

Certain forms of mental illness such as alcoholism and drug addiction [6] have received special attention from the church. Alcoholism has long been a concern of the Salvation Army. Alcoholics Anonymous, an association of chronically alcoholic persons, is basically religious. Both of these can be credited with many successes. Of interest in this connection is the fact that the Yale Summer School of Alcohol Studies is attended by ministers and other religious workers.

Suicide also has special meaning for the church, often with inadequate recognition that it is usually symptomatic of serious mental incapacitation. A symposium on suicide from the church's standpoint is the subject of one number of *Pastoral Psychology*.[7]

Some churches, notably the Roman Catholic, provide extensive inpatient and outpatient services for the mentally ill. Sometimes when the rest of society finds the mentally ill, delinquent, or mentally deficient not worth the effort of training or treatment, the church steps in with its invariable devotion to human worth and gives aid.

PERSONNEL

The mental health potential of the church is in part made possible by the very form, tradition, ritual, and atmosphere of the church itself. But the personal qualities of the clergyman cannot be ignored. The clergyman is personally inseparable from all that he does, excepting on such dogmatic grounds as divine mediation. It is therefore just as possible for personal peculiarities to handicap clergymen as those of other professions. It is similarly possible to reduce this interference to a minimum either by his coming to understand himself better and modify his liabilities or to depersonalize or standardize his pastoral functions to the point where his personality functions at a minimum. If he does the latter, his counseling and educational function is also neutralized.

The full mental hygiene potential of the church calls for the special preparation of clergymen in health, psychology, sociology, anthropology, and community organization. They must know how to identify and help those in need and also how to assist and be assisted by other professions. The theological school can include both theory and supervised practice with cases in its training. Clinical pastoral training was proposed as far back as 1913, but it actually got under way in Cincinnati in 1923 and has expanded since then. This training includes a period of supervised experience with hospitalized psychiatric patients.[8] One training program offers courses in clinical pastoral training in mental hospitals and operates with the approval of the Institute of Pastoral Care of the Massachusetts General Hospital in Boston. Several affiliated seminaries participate in these courses. In California,[9]

> The training program includes observation of hospital facilities and treatment; clinical studies and lectures by the hospital staff; initial religious interviews with

new patients listed as Protestants; follow-up pastoral counseling with selected patients; attendance at weekly group meetings with relatives; assisting in religious services; and regular conferences with the hospital chaplain in charge of the training program.

In order to make the most of this clinical training there is also need for supervision from within the field. The techniques of student supervision which have been developed in psychiatry and social work have much to offer in the training of clergymen.

In view of the similarity between pastoral counseling and psychotherapy, it is important that every effort be made to avoid confusion as to the functions of clergymen and psychiatrists or other clinicians. Confusion on the part of the clergyman is seen in such terms as "pastoral therapy." The term *ministry* embodies a fairly complete sanction for what the church has to offer without recourse to a hybrid of two professions. In order to ensure the best teamwork between doctor and clergyman, the doctor and his associated professions also need training to understand the function of the church and coordinate their work with it. Psychiatrists get little of this training. The doctor needs to be as clear as possible about the limits of his own competence in dealing with religious problems.

Again and again in this chapter it has been pointed out that the church in fulfilling its mental health functions does well to join hands with other agencies that are similar in goal but different in their technical contributions. This point cannot be stressed too strongly, for the mentally ill who are already bewildered are not helped by the added complexity of agencies that cannot work out their interrelations sufficiently to unify their efforts.

NOTES

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19 MENTAL HYGIENE AND THE SCHOOL

Education is the cultivation of human potentialities so that they may be turned into effective action. The responsibility for developing the potentialities of the child starts with the family. But as the social group in which the family lives becomes more demanding, more complex, less permanent, and less intimately related to it, the family finds it harder to transmit the prevailing social customs and values to the child. Especially is this the case as the family circle contracts and the opportunity for social experience within it is lessened. To compensate for this limitation, society has given more and more sanction to the school as an agency for positive mental health. In a special study Ryan[1] has interpreted education as essentially a mental health function. He has continued that principle in a mental health periodical[2] for teachers which he edits.

MENTAL HEALTH ROLE OF THE SCHOOL

The fact that the school concerns itself with mentally handicapped children does not negate its essentially positive role. It follows the principle that every child is unique and that the best education is that which takes individual differences, even to the extreme of mental handicap, into account. These individual differences are partly constitutional and partly cultural.

Over the years the educational profession has produced a large body of scientific knowledge which enables it to function by design instead of by intuition only. Most of this is essentially a part of psychology and is the result of efforts of scientists in that field to understand human development, processes of learning, methods of evaluating (testing) potentialities and achievements, methods of analyzing special defects, effective measures of remedial education, and processes of interaction between pupils and between teachers and pupils. This science helps the teacher to assess potentialities of the pupil and to apply well-tested educational techniques. It enables him to understand and deal with many of the emotional interferences with learning, to arouse interest skillfully, and to facilitate learning. The teacher knows that education cannot be impersonal, since the emotional relationship between pupil and teacher is a great factor in the school's success.

The school begins to serve the child only after many habits and attitudes have been established by his home. If the home has been lacking in security and affection, the school can help by being a friendly place, but the teacher is a part of the child's life too briefly to fully balance the loss. Affectionate and comfortable human relationships are so important as vehicles of learning that the child's preschool experience has much to do with the teacher's success.

The science of education is, however, only the servant of an educational philosophy. Science helps to achieve a goal, but the goal itself is determined by society and expresses society's values. The sociologists and cultural anthropologists have offered much to education in understanding these values. They are so basic and often so variable from country to country that the uncritical adoption of educational techniques and goals that serve well for one culture may be prejudicial to mental health in another.

The public does not grasp the subtleties of the social sciences. In a mixed population the school may lose popular support because it seems to undermine customs and values that some of the families hold dear. The school cannot be expected to carry on the customs that prevail in the home, especially in large cosmopolitan centers where cultures are diverse. It can only try to provide a setting where the family's values can evolve so that all in the classroom can find a way of living together comfortably.

Beginning with the Commission on the Reorganization of Secondary Education in 1918,[3] statements of the cardinal objectives for education have repeatedly placed "education for health" first. Education for health has, however, been crowded out of top position in the school's contribution. Mental health suffers more than any other aspect of health from lack of support, for it must be considered in the whole of the school's work. In fact, mental health and education are so inseparable as often to be considered one and the same. Mental hygienists, including educators, are concerned with this one objective—to develop potentialities of the child for meeting life's situations satisfactorily.

Statements of progressive educational policy that are voiced from time to time are so far in advance of actual practice that one is apt to think of them as revolutionary. Historical comparison, however, shows this newness to be more apparent than real. Burnham[4] compared leaders in education over two millennia and found their principles the same and also identical with those of mental health. There is need, not for further repetition of the principles of education, but for determination of the causes of their neglect and a strategy of progress that takes these causes into account.

Since mental health is the goal of education, there is no one aspect of education which can be properly termed the mental health aspect. This chapter, therefore, for reasons of space attempts only to convey an understanding of the identity of education and mental health and to suggest some ways of turning this principle into practice.

THEORY VERSUS PRACTICE

As has been stated above, there is a serious gap between the school as it is and the best schooling that science has to offer. This lag pervades the school. But certain failures bear more heavily upon the mental health of pupils, school personnel, and families. A confidential talk with any good school administrator will show how great has been his struggle to maintain good standards and how little help he is given in answering many questions that bear on the mental health of his pupils: What happens to the child as he makes the transition from home to school? What problems are there in maintaining a school atmosphere that encourages the realization of potentialities? What are the dangers in assessing a child's potential by inadequate personnel and methods? What obstacles are there to the cultivation of potentialities, especially the unusual ones? What does the school's failure (usually termed the child's failure) do to the pupil's mental health? How can the school help the deviant? These are daily reminders to the good educator that he needs better support to do the job that is expected of him.

There are, of course, educators who are not concerned about these matters. Some of them were concerned at one time but have surrendered in despair to expediency. Others are mere jobholders whom the public holds in readiness to be ousted if things go wrong. But ousting the mere jobholder is no solution. He is so often the best that the public was willing to buy. When too many children fail, misbehave, or prove unprepared for work or college, the public becomes indignant and makes him the scapegoat for its own failure. But there is little hope of progress for such an unregenerate public. A good educator is courting trouble if he succeeds a scapegoat unless there is a vigorous, even if small, group of citizens to give him enlightened support.

It is usually hard to get the public to understand that the good teacher is an expert in education, not merely a driller of pupils. It, therefore, fails to provide the financial support and even sometimes the sanctions that are needed to give the child the best education that science has to offer. As a result the school cannot adhere to the ideals and objectives that leading educators have voiced. Too often even educators themselves have surrendered in despair.

Isolation may befall a school as well as any other institution. It may be less susceptible to this danger than is the mental hospital because it is set in the center of population and its clientele is not sequestered. These factors, however, only make the danger of isolation insidious. In fact, the less geographical conditions can be counted on to provide isolation, the more must the person who uses that form of defense depend on developing a psychological hard shell about himself. This hard shell is in fact harder to change than is one's geographical location.

Any failure of the school to reconcile its services with those of other agencies and social institutions that affect the child is likely to confuse the pupil and his family. Sometimes to avoid "foreign alliances" schools try to meet the health, welfare, and recreational needs of their pupils within their own jurisdictions, but this omnibus arrangement is deceptive. It is never comprehensive enough to obviate the need of integrative collaboration. Obviously health departments and schools are mutually dependent.

THE SCHOOL ATMOSPHERE

Wherever a person lives and works his mental health is influenced not alone by the tasks that utilize his technical skills—housekeeping, doing arithmetic, or working on an assembly line. He is always living in a psychological and social atmosphere that influences his use of his skills. Where the use of his skills has become automatic and routine, they are apparently less influenced than where they are being learned. The atmosphere of the classroom, therefore, may make the pupil's efforts painful or satisfying. It may hasten learning or contribute to failure.

An unwholesome school atmosphere may be caused by a mentally disturbed pupil, but more than anything else the classroom reflects the personality of the teacher. The teacher who likes children and makes them feel that he likes them is helping them to mature. If at the same time he understands and respects their limitations, they more readily accept firmness when they need that kind of support. If the teacher himself is so much in need of being liked that he retaliates when the pupil is unfriendly or is too lenient when the pupil needs firm support, he is failing professionally. If rules can be modified in keeping with the needs of the pupil instead of being protected at all costs, the teacher can do much to sweeten the school atmosphere and lighten his overload of work, failures, anxieties, and worries. All too often the feuds, jealousies, and other conflicts between teachers erupt as tension between the teacher and pupils in the classroom. In any case it is difficult, if not impossible, for a tense, unhappy, dissatisfied teacher to maintain a wholesome classroom atmosphere. Nor is it easy for a basically good teacher to avoid being tense when her room is overcrowded and she is given poor support from the school administration. It is the poor atmosphere of the classroom and poor mental health of the teacher more than the lack of tricks in teaching reading or calculus that cause an undue number of pupils to be referred for psychiatric service from certain classrooms. It is interesting that the mental health leadership among educators has come so often from teachers of literature. This is not surprising, since literature and history are two areas of education that deal especially with people as they live, express their potentialities, and strive for satisfaction.

Especially significant to mental health and the school atmosphere are the studies that have been made of the emotional relationship between pupil and teacher. Educational associations have issued many reports in which the mental health of the pupil is made the base line for educational policy and techniques. The study by Wickman [5] was a pioneer effort to analyze this element. It has become a classic. Also of far-reaching significance is the work of Prescott [6] in which the emotional interaction or interplay between pupil and teacher is analyzed. Especially significant is the more detailed effort by Baxter [7] to scrutinize the emotional relation between teacher and pupil and to discern in it the emotional vehicle on which the subject matter passes from teacher to the pupil. Harold Anderson [8] has extended this search and has revealed the continuity of this emotional relationship. The technique of sociometry is of value in measuring the aggregate effects of the many psychological forces upon the attitude of pupils toward each other. These are but a sampling of the ways in which psychology has helped to bring the process of education under control and focus it upon the child and his mental health instead of merely upon his capacity to recite a lesson.

TEACHING PERSONNEL

It is evident that if the school is to cultivate positive mental health it must have enough well-equipped teachers. The salaries must be attractive, but the job and even more the profession itself must be enticing to mentally healthy and inspired teachers. Care is needed both in training and in selection to ensure teachers who will contribute to the healthy mental development of the child.

Prior to World War II many teachers colleges trained more teachers than they could place. Some were opposed in principle to the selection of students, but others tried to select students whose own mental health would influence the mental health of pupils favorably. Since that war the situation has changed. The competition of other careers has eliminated the excess of teachers, so that at present there is less choice. In many teachers colleges the general caliber of matriculates has been inferior to that of liberal arts and professional schools, whereas in other places the caliber has been as good or better.

Since the mental health of the teacher is so important in determining the atmosphere of the classroom and the effectiveness of the pupil-teacher relations, mental health becomes an important element in selection and education of the teacher.

In 1953 the National Conference of Physicians and Schools considered the mental health aspects of teaching. One section of this conference [9]

> . . . agreed that teachers strongly affect the mental and emotional health of children and that, for this reason, teachers must be thoroughly well-adjusted persons in order to carry out proper teaching approaches. This, it was pointed out, called for better selective processes in universities or colleges which train teachers. The group felt that before this selective process could be successful, there was need to establish criteria that would raise the standards for selection

of teachers. It was suggested that an organization, such as the National Education Association, undertake the setting up of a committee whose aim would be to establish such criteria.

Most students come to teachers colleges with emotional maturity that is in keeping with the average of their age. Some, however, lag in this respect. Some students are immature because of unfortunate childhood experience that has stunted their emotional growth. They are the neurotically handicapped. With help some of them can be fitted for a teaching career. Other immature students are not neurotic but merely slow in development. They are healthy and turn out well if dealt with in keeping with their level of emotional development. It is often hard for a teachers college to make this distinction. It is not easy to get a true evaluation of an applicant, because the local school authorities are under so much pressure from the relatives and friends of an applicant that they hesitate to give a frank report if it is likely to lead to rejection.

Within the curriculum of the teachers college, mental health becomes an issue at almost every point—orientation of the student, health services, health courses, faculty-student relations, extracurricular activities, counseling, and placement. Some teachers colleges that are required to graduate a student who passes academically add a personality evaluation to the academic rating of their graduates. The personal evaluation may have to be unofficial.

The education of a teacher to further the mental health of the child by no means ends with graduation from a teachers college. It may be continued through postgraduate work. But more important is the education that occurs under good supervision and consultation on the job. This principle has guided a special project in the New York City public schools.[10] In this project pupils whose problems are beyond the capacity of the teacher spend part time in a special room. Here they are studied by an especially equipped counselor-teacher who devises techniques to meet their particular needs. The pupil is then returned to the full control of the classroom teacher, to whom the project teacher reports her findings and techniques. The regular teacher carries on from that point. In this way the competence of the classroom teacher is enhanced.

New York State[11] and California are exceptional in having interdepartmental commissions which include, among others, representatives from both the Department of Education and the Department of Mental Hygiene. Out of a conference held in 1951 by the New York Commission, the State Education Department has undertaken to stress the in-service training in mental health for teachers and to hold conferences on mental health for school authorities.

School administrators and school boards may differ greatly in their governing philosophy. This will influence the kind of teacher that they seek and the compatibility of the atmosphere in which the teacher must work. A teacher who has developed a flexible concept of his functions may find himself in a system which is rigid or authoritarian and which does not permit adaptations to the needs of individual children. Such a teacher may be so unhappy in that rigid setting that he is less effective than one who is in harmony with the prevailing philosophy. It is, therefore, often hard to rate the essential qualities of a teacher by his performance apart from the total setting.

Boards of education choose teachers, as a rule, only in small communities, but are often incapable of choosing a good teacher. Too often they favor the kind of teacher and subject matter that prevailed "when I went to school." They may equate all teachers holding certificates, making no allowance for supplementary evidence of competence. They are apt to favor the applicant from local families of greatest influence. The mental health of the candidate and his influence on the mental health of children are usually ignored. Too often, if a teacher fails, the board lays the full blame on him. It does not recognize that the fault lies in the inadequacy of its methods of selection.

Educators have among their tools scientifically constructed guides, techniques, and psychological tests to help in the assessment of the pupil. Some of these instrumentalities should be used only by especially trained persons and, therefore, are not used routinely. Tests are best used as a part of a broader assessment of the child, for none is comprehensive or reliable enough to be used alone. A report on school health policies[12] prepared by the National Conference on Cooperation in Health Education stresses the importance of informed observation by the teacher to detect the need of the pupil for special examination and study by the psychologist or visiting teacher. This should not be merely an occasional detached observation for physical health purposes only but should be a part of the teacher's continuous alertness to the child's behavior.

Pupils come to school with widely differing talents, interests, and personality characteristics. They mature psychologically as well as physically at different speeds so that care is needed lest slow development be mistaken for mental deficiency or retardation. Unless the school adjusts itself to these normal differences, it may nullify good rearing within the family, where intimacy and small numbers make individualization easier.

In the transition from home to school, the child's mental health is often left to chance. In addition to social differences children come to school with varying degrees of emancipation from the family. The teacher needs to be expert in facilitating this transition, in furthering the child's emancipation, and in aiding his maturation. If the school is careful neither to force nor to obstruct the child's tendency to depend on himself, he is less apt to fear his own growing up or to rebel. If the pupil is helped to progress emotionally he begins to aim his efforts at the product of his work and to get satisfaction from that rather than from the mere approval of an adult. He loses the attitude that a task, like a school test, is done to get someone else's approval. Instead he accepts the task as a creative opportunity from which he can get satisfaction. Some pupils never make this shift.

A good school recognizes that maturing is a continuous process. Its opportunity to aid in the transition from dependence to a comfortable nonrebellious emancipation is not limited to the primary grades but goes on throughout school life. There are, it is true, more critical periods such as beginning school or college, changing schools, leaving home, going to work, and joining the defense services when the maturity of a person is seriously tested. But in between there are shorter steps which when negotiated successfully make the greater ones less critical. The teacher is emotionally so important in the child's life that willy-nilly he will either hasten or retard the transition.

The processes and criteria of promotion, of periodic reporting, and of grade placement may all jeopardize mental health. These customs too often lead to worry, pressure, and criticism within both the home and the school. They are used as measures of success and status not only of the children but of their parents and the teachers themselves. Leaders in the field of education recognize this fact and try to do something about it. Some schools have provided for periodic conferences with parents in order to report more constructively on the child's progress and to emphasize the fact that school progress is a product of both the home and the school. But the public frowns upon discrimination and flexibility based upon individual differences, for these seem like coddling. It looks upon good grades, good reports, and promotion as rewards and dislikes attempts to alter these devices. To the professional educator these devices are servants, not masters.

SPECIAL MENTAL HEALTH PERSONNEL

The school psychologist is an essential adjunct to any school system, for he is able to assess the pupil more specifically and reliably than can the teacher. The psychologist's evaluation enables the teacher to know the pupil's capacities and to plan for his development. Unfortunately there is usually not even enough personnel to provide psychological service to pupils whose problems are critical so that little is done toward routine assessment. In many places psychological service is provided only by psychiatric clinics. The American Psychological Association is the major professional association for psychologists.

The visiting teacher or school social worker helps the school to understand the social situation from which a pupil comes and facilitates collaboration between home and school. But the school social worker, like the psychologist, is almost completely occupied with more critical problem cases. The need for the social worker is especially great in urban communities, where teachers may live far from the neighborhood which the school serves and know little about it. The rural teacher, on the other hand, is more apt to know the family of each child, the economic situation, the religion, and the father's occupation. The techniques employed by the school social worker or visiting teacher are essentially those of the social case worker rather than those of teaching. It is, of course, helpful if the visiting teacher is oriented in pedagogy, but that is not the basic skill. Sometimes, however, the school authority reverses priorities and places the teacher's certificate first. Perhaps it is because he is more comfortable with personnel qualified in his own field. As a result a good teacher is appointed as school social worker and is required to "pick up" the social work techniques as best he can. The National Association of School Social Workers is the national professional association in this field. It sets professional standards, advises those contemplating a career in school social work, and counsels schools and others who are interested in establishing school social services.

Many teachers are all too ready to unload the responsibility for the difficult pupil on the psychologist or social worker. When the classroom is overcrowded, this readiness is understandable. Nevertheless the teacher is pauperized professionally when he is relieved of responsibility for difficult cases. Some schools consider the visiting teacher as an aid to the teacher on all cases rather than a burden bearer for only his difficult problems. The visiting teacher under this concept becomes a force in building up the mental health potential of the school.

Counseling is an integral part of the function of the teacher. Yet there are occasions when special counselors must be called upon for help to the student. This may be because the regular teacher is not skillful at counseling or because the problem calls for exceptional knowledge and skills, e.g., vocational counseling. Farnsworth [13] has pointed out some of the principles that should guide counseling, by whomever it may be done. Briefly, these include the following:

1. The student should be helped to solve his problem himself.
2. The student should be helped to discover and evaluate courses of action.
3. The student should be helped to deal with his essential problems which he may try to suppress, not with a more comfortable substitute.
4. The student should become the judge of his own behavior.
5. The student should determine for what problems he will ask help and be counseled.
6. The counselor must decide whom he should help and for what.

It can be seen that underlying all these principles is respect for the student and his right of self-determination which, of course, will differ with degrees of maturity.

More closely identified with positive mental health are certain mental health programs for all pupils.[14] Bullis,[15] for example, has promoted discussion classes known as *human-relations classes*. Each class session begins with a provocative story or other incentive to discussion. The class is then encouraged to talk along any line of interest that this initial stimulus presentation may have aroused. In this way the pupils formulate their thoughts about real-life interests (sometimes problems) and exchange thoughts with each other. They see their own ideas more objectively and also see how their views or interests compare with those of the others.

Schools have sometimes had to provide their own mental health clinics because the appropriate authority in the community or state has failed to do so. However, where a clinic is available for the community, it is common practice for the schools to collaborate closely with it. Early in this century the state school for the mentally deficient at Waverly, Mass., provided a clinical team to the schools within its district to identify and plan for the mentally deficient and retarded. The Essex County Juvenile Clinic, Newark, N.J., under Dr. James S. Plant, offered both clinical and consultation services to schools as a means of mental health education of teachers. Most community mental health clinics work closely with the schools in the treatment of educational and behavior problems. Sometimes a school psychologist and visiting teacher serve as virtual staff members of a clinic when their pupils are being served by it. The close alliance of school and clinic has been made the subject of special experimentation in Phoenix, Ariz., where a clinic [16] and the local schools work hand in hand on behalf of the child. From the intensive study of the problems in these cases the school learns something of its own shortcomings and is able to institute preventive measures on behalf of all the pupils.

Earlier in this chapter it was pointed out that concern for those who vary from the norm is inherent in the general principle that the school should adjust itself to individual differences. While a child who differs from his classmates may call for more of the teacher's time and skill and require special provision, that in itself does not imply that the deviation is an inescapable evil. A study of so-called isolated school children,[17] i.e., those who have little to do with their classmates, showed that some were quite healthy mentally. These were children who because of unusual talents and interests had little occasion to collaborate with others. They were not unhappy about their isolation since they were socially acceptable, were respected by their classmates, and were getting satisfaction out of the realization of their potentialities. Still, such pupils could very well be damaged were the school to fail to respect their differences and give them help in developing their potentialities. When the public makes school attendance compulsory it thereby takes on a moral obligation to provide for those who are exceptional and who require higher expenditures than the average. This obligation is well expressed in a statement emanating from Belgium: [18]

> It is the bounden duty of the public authorities, who have introduced compulsory education, to insure the elimination of retardation in schools, for if children are obliged to go to school, care must be taken to make certain that teaching is so well adapted to all needs that the children are always sure of deriving benefit therefrom. While selection is one of the features of post-primary education, the keynote of basic education, on the contrary, should be adaptation

to each individual case. . . . Consideration of our efforts in the field of education conveys the impression that we pay more attention to the gifted than to the weaker pupils. Our attitude toward intellectual "capital" is still comparable to that of the newer countries toward their natural resources, when they concentrate more on the richer than on the poorer deposits. Spiritually as well as socially, we still have some leeway to make up; for we are not a new country any longer, but a developed democracy. And under present day democratic conditions, when every human being has his own, absolute value, the right-minded nation is that which, having taken the necessary steps for the training of its leaders, blows into a flame the slightest spark of intelligence or goodwill emerging from the least of its members, and makes them into men of worth and independence.

TYRANNY OF THE AVERAGE

It is not unusual for society to measure its obligation to a pupil by what the pupil will give society in return rather than by the more humane principle that the pupil has a right to development no matter how limited his talents are. When the public through its schools follows the latter principle it protects the child's mental health as well as his talents. Those who are especially interested in gifted children can make a contribution to all children by making it clear that both gifted and handicapped children are stunted and emotionally impoverished either by being forced to drag their feet or by being rushed into a stumble in the path of the theoretical average.

Leaders in the field of education are fully aware of this tyranny of the average. They need no other professions to remind them of it, but they do need sympathetic support. They are severely frustrated by the failure of the public generally and school boards in particular to equip the school to deal adequately with individual differences. They know that many a child is unable to encompass the three Rs not because of limitations of intelligence, but because emotional disturbances interfere. They know that these disturbances affect every aspect of the child's life. The tasks which the school places before the child bring his problems to light. In so far as it fails to take them into account, it produces further disorders. Many private schools have an undue proportion of emotionally disturbed and otherwise mentally handicapped children and youth who have not found help in schools which are adjusted only to the near average.

The usual course, however, for the pupil whose school has failed is to leave school as soon as the law allows—or sooner—and enter the ranks of child labor. Those who are interested in safeguarding young workers against exploitation, such as the National Child Labor Committee and the Bureau of Labor Standards of the U.S. Department of Labor, recognize that children are discouraged out of school as well as encouraged into work. They concern themselves, therefore, with efforts to make the school experience more rewarding, instead of depending merely upon legal controls over child labor. The National Child Labor Committee is also concerned with the positive aspects of work for young people when that work is made safe and free of exploitation.

The plight of the mentally deficient has already been presented in Chapter 9. But between the mentally deficient and the child who can adjust to the regular curriculum is a group of slow learners. They are capable of living useful independent lives, unless they are damaged emotionally. But they are a vulnerable group, since they have limited reserve. They should, as far as possible, be kept in the regular classes. But unless the school's expectations of them are adjusted to their potential their mental health is almost certain to suffer. Some of these pupils work out their own, even if socially undesirable, adjustment. By truancy they are protected from the embarrassment of failure. By delinquency they may meet their material needs and give vent to the hostility that the neglect by society has helped arouse within them. Some of these children would advance steadily, even if slowly, in school were it not for the emotional turmoil that disintegrates whatever scholastic potential they possess. This disintegration shows up in school especially in reading deficiency and speech disorders. Skillful coaching may help to break into the vicious cycle of failure, emotional disturbance, and more failure. But when the emotional disturbance comes from factors outside the school it is too much to expect these special defects to disappear merely through an enlightened school.

COLLEGE MENTAL HEALTH

It is easy for the student in college to waste his talents, since his special abilities may escape attention as long as he is making passing grades. College life is a test of the mental health of a student, for in college he is undergoing a transition from dependency to independence. This test may bring out weaknesses that he has previously been able to handle. Too often his inability to meet the test terminates in psychosis and suicide. Since the early 1920s colleges have given more and more attention to mental ill-health among their students, but progress has been slow and most colleges still do very little. Some deans of students have been freed of most administrative duties and have become primarily personal counselors. Many departments of education and psychology offer counseling service to students, and some student health services have been strengthened to deal with mental problems.

Among the students who fail and leave college are some whose problems have been seen only as an academic failure but who in fact are mentally ill. There is need to study failing students routinely in order to reveal wherein the college has failed and how a disorder might be discovered and treated earlier. Early discovery of the problem depends largely upon the instructor who sees the student regularly and is constantly putting him to test. Unless he can sense a disorder and know what to do about it, his neglect or fumbling may be disastrous. Unfortunately the college that has funds enough to provide personal mental health services for its students is usually too large and complex to make structural changes in behalf of student mental health that are dictated by case studies. The smaller college, in which faculty cooperation might be worked out more easily, has not the personal counseling and treatment services that would reveal its needs.

In any case college faculties are tempted by *administrative ease* and resist change just as do the personnel of other agencies. This resistance slows the effort to make of the college an agency which is as concerned with mental health of youth as with subject matter. The mental health of students would seem to require that the teacher as a professional person be expert at detecting failure and at determining its general nature; avoid aggravating it; if possible, ameliorate the problem; and know the resources that may be called upon for help.

How inextricably the problems of the college student are bound up with all other aspects of his life outside college is well shown by Farnsworth.[19] His exposition shows how impossible it is for the college to serve the student if it operates in isolation.

MENTAL HEALTH SIGNIFICANCE OF SCHOOL

The significance of the school as a force bearing upon mental health is determined in part by its extent. About five-sixths of the population 5 to 17 years of age are enrolled in public schools, and on the average there is approximately 88% daily attendance. Of the remaining sixth of the population a large part attend private, mostly church, schools. A small percentage have quit school and perhaps have taken jobs. When it is considered that the school absorbs a quarter of the child's waking hours, its impact can be seen to be tremendous. In addition, the kindergarten, nursery school, and institutions of special and higher education extend this force still further. It is not uncommon for twenty years of one's life to be spent under some form of professional tutelage.

The social significance of the school is not measurable. It is generally accepted that the school is an indispensable instrument of modern society, but there is no satisfactory way of measuring its impact. The costs to the taxpayer of public schools alone are estimated to be $8,000,000,000 per year. The social cost of grade failure and repetition is only partially measurable in money. The costs of delinquency, dependency, and mental ill-health to which inadequate schools contribute must be added in estimating the total social import of schools.

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20 MILITARY DEFENSE SERVICES

Like the college, the defense services—Army, Navy, and Air Force—deal with youth in transition from dependence to independence. They absorb a youth when a life career and marriage are appropriate preoccupations. They draft him at the culmination of a long indoctrination in democracy. They, on the other hand, offer him many positive opportunities. The defense services are adjusted primarily to normal persons. Training is designed to reveal and test their potentialities and develop them for specific purposes. Selection of personnel is, however, more often negative than positive in that a man is rejected for well-defined disabilities but not accepted for well-defined assets. Many of the problems are similar to those that confront the civilian school. But the serviceman continues after training to work under the same auspices. This should make it easier for the armed services to discover their mistakes and to change their training processes accordingly.

Of course, the Armed Forces do not exist in a vacuum. They are a part of the citizen-sanctioned democratic governmental structure. It is, therefore, important that the public understand and support their efforts to individualize assignments and that it not mistake these efforts for favoritism.

HAZARDS

Since the defense services are seldom a chosen career entered voluntarily, they may interfere seriously with a young man's vocational plans. They constitute a psychologically hazardous occupation for youth in our culture wherein regimentation is frowned upon. Ginzberg, Herna, and Ginsburg,[1] in a study of psychological factors in the Armed Forces, canvassed the opinions of many psychiatrists who had had military experience. This canvass revealed the danger to youth of making the transition from a civilian atmosphere of self-expression to military regimentation. Criticism was leveled at the wasteful selective process under which so many men broke down during the first three months of service. It was felt that mental health could be protected at that time, with great saving of valuable manpower. It is now better recognized that the military patterns which seem to work well in more authoritarian societies may be unsuitable for a democracy.

The shift from civilian to military life is especially hazardous to women. These recruits are usually not aware of the extent to which they have depended upon cultural supports in the community to guide them and of the hazards attending the removal of these supports.

The effectiveness of the Armed Forces depends heavily upon their *esprit de corps,* and some of their efforts are directed toward strengthening morale. For example, they may, because of the influence on morale, continue to render medical service to personnel destined for discharge. This should sensitize them to the fact that they are dealing essentially with people, but sometimes they deal with men in the same impersonal fashion as with matériel. For example, one of Ginzberg's respondents deplored the holding of replacement personnel in a pool without any effort to identify each man with a specific outfit.

Those who have dealt with disturbances of morale and the failure of men to use their talents lay great stress on the importance of mature leaders, improved systems of rotation and replacement of personnel, and help to the recruit in the early stages of his training when he is anxious and strange. They warn against rewarding failure by relief of duty. Instead they favor high incentives for effective performance. Ginzberg advises several steps to advance the mental potential of the armed services: (1) a reevaluation of the policies of military manpower management; (2) care in using statistical data from World War II, since they may be misleading and confusing; (3) evaluating the stresses and supports of the military environment in order to understand what happens to individual strengths and weaknesses; and (4) using information about preservice civilian adjustment as an indication of probable military adjustment only if the analogies between the two are established.

On the other hand, this period of training and experience may help to uncover and develop talents. In spite of the necessity for regimentation there is a growing consciousness of the need to assess and assign the serviceman in keeping with his assets and liabilities. This assessment cannot be a "one-shot" effort by Selective Service or the preinduction examining stations; rather, it must be continued until a successful assignment is achieved. One of Ginzberg's respondents emphasized the seriousness of proper assignment and deplored instances in which men with valuable qualities were made ineffective by assignment to work for which they had neither interest nor skill. In proper assignment lies the potentiality of the Armed Forces for positive mental health.

The mission of the Armed Forces requires the identification of those psychological qualities in their men that may influence their effectiveness. Some of their qualities are negative, e.g., mental deficiency. Others are positive. The responsibility for this identification extends far beyond the medical and psychological service right into the command. To this end there was published by the National Association for Mental Health during World War II an unofficial mental hygiene first-aid manual [2] which was used extensively in officer training. This is an example of civilian help to defense authorities in furthering mental health.

Two other civilian agencies, the Red Cross and USO (United Service Organizations), are favorably situated to contribute to the mental health and morale of the armed forces and to detect the beginnings of failure. The Red Cross helps the serviceman during emotional crises, such as the death of a parent. The informality and absence of authority of USO enable servicemen to reveal their needs and problems very often before they are sensed by their officers. Most civilians do not understand the internal processes of a defense installation and are often too ready to criticize. Many installations, therefore, encourage their officers to participate in nearby community activities. Especially active and helpful in gaining civilian support are officers who have to do with health, morale, discipline, leadership, and evaluation, such as chaplains, psychologists, social workers, recreation workers, and physicians. Community agencies can be very helpful to the families of defense personnel who are so often transient and have no intimate friends on whom to depend. Community agencies and persons are often called on to give marriage and family counseling to such bewildered families. During World War II civilian citizens also helped Selective Service Boards and Induction Stations to gather information about candidates for use in their assessment. This was helpful also in securing public sympathy for mental health measures within the services.

DEALING WITH MENTAL DISORDER

Incidental to their essentially positive nature, the Armed Forces must identify and treat the mental deviant. In this their policies are determined by their mission. In every act these services are motivated directly or indirectly toward the provision of successful combat units.

During World War II, as of August 1, 1945, 18% of the nearly five million Selective Service registrants aged 18 through 37 years had been rejected for mental disorders. In addition large numbers were discharged for the same reason. These figures are not a measure of the incidence in the general population, since the stresses of military life are exceptional and there are rewards for mental disability in the armed services which aggravate, perpetuate, and perhaps even precipitate the disability. The first step in discovering the mentally ill is actually outside the Department of Defense and in the independently administered Selective Service System. This System is so intimately related to the Armed Forces that the mental health functions of the two must be considered together.

SELECTIVE SERVICE

Selective Service is the process by which a community determines which of its young men shall be submitted to the Armed Forces for possible induction. Each district or community has its Selective Service Board in whose hands rests the authority for classifying its men and determining their availability in accordance with law. Those whom it finds eligible are ordered to the Armed Forces Examining Stations. The Selective Service function is, therefore, closely related and complementary to that of the Armed Forces Examining Stations. Since the Selective Service Boards are limited in their authority to exclude candidates because of milder neuropsychiatric disabilities, the obligations of the examining stations are correspondingly increased. Selective Service also influences civilian mental health. It is often the first to identify those who are rejected for gross mental disability, and it is in a position to guide them to help. Those classified as conscientious objectors remain in civilian life and are subject to special hazards to mental health from which wise handling may protect them.

The procedures employed by Selective Service Boards in the performance of their duties are controlled from the national headquarters only in the most general way. The general policy is to place upon the local Board the fullest possible responsibility. The medical prerogatives of Selective Service are limited to the rejection of only the most grossly and obviously unfit. Many of those rejected for mental disability have therefore already been identified as serious problems. Of the men processed by Selective Service for the Armed Forces preinduction examination, 2.0% are classified as unavailable because of psychiatric disorder. Its decisions are therefore less handicapping to the milder case than was the case during World War II, when the 4F classification was made for less obvious disabilities and constituted a serious social as well as occupational handicap. A reliable record of the candidate is, of course, helpful in evaluating him.

The selection of personnel for the Armed Forces is subject to many influences from within and without. Officers in the armed services vary greatly in their attitude toward strict selection. Some would rather not be bothered with their weaker brethren. Others feel that a firm command can compensate for all weaknesses, and these have no patience with careful selection. Some civilians suspect favoritism if the basis of rejection is not obvious. Some candidates try to escape service by subterfuge and may be aided and abetted by friends. Thus local bigwigs sometimes try to secure the exemption of a "favorite son." Others may seek the relaxation of standards in order to get a misfit, an alcoholic, or some other problem case into the service in order to "make a man of him."

During World War II the exemption of the neurotic varied from time to time in response to the need for men rather than the compatibility of the man and the military service. A neurosis is so specifically related to one's life situation, especially his work and his family, that his suitability for military service cannot be safely prejudged by his civilian adjustment.

The handling of conscientious objectors in the past has often been emotionally disastrous. Today they are assigned to a civilian public service but have considerable choice in the selection of their placement. When on the job they may work under the same conditions, including remuneration, as the regular employee.

THE ARMED FORCES EXAMINING STATIONS

The Armed Forces Examining Stations are located in various cities distributed over the country and are under the authority of the Department of Defense through the Army, although they serve all three branches of the service.

Men whom Selective Service classifies as available to the armed services are examined personally at these stations. The preinduction examinations are, as a rule, carried out in two stages. The first and more important examination is carried out well in advance of induction. The second examination given at the time of induction is very limited and only grossly concerned with mental health.

Early in World War II these stations rejected many men for minor personality deviations and neurotic susceptibility. Later it was the policy to admit to the Armed Forces every man who had a reasonable chance of success, leaving it to the forces to work out his salvation. More and more the past adjustment of the candidate and the conditions under which he lives are considered in estimating his prospects. Civilian agencies may perform an important service to the candidate as well as to the Armed Forces by contributing such data, positive as well as negative, as is within their discretion to transmit. This need not be fine detail, for while urban localities are able to provide more detail than rural communities, rural screening seems not to have been followed by a greater incidence of maladjustment within the services. Once the unsuitability of a candidate is decided the examining station does not try to refine the diagnosis.

A candidate is usually considered mentally normal if the examination and record suggest that he may get along tolerably with others, is sexually normal, has no gross deficit of intelligence, and has enough stability and ability to work steadily. This is the operational definition of mental health in the Armed Forces. Stuttering, psychoneurosis, and even a history of transient psychoses are thus considered potentially compatible with military effectiveness.

By the same token incapacitating deviations are a bar to acceptability. Severe emotional instability, psychoses, gross personality deviation, and mental deficiency may be disqualifying. Borderline cases are usually disposed of after induction. But if there is promise that brief hospitalization before induction will resolve the doubt, the examining station may hospitalize the candidate as a part of his preinduction examination. In actual practice the psychiatric examination of the candidate is carried out after the completion of the other medical examinations and whenever the examining physician is in doubt. For this reason the statistics on mental disorder are minimal.

Less than 2% of candidates are disqualified for mental disorder by the preinduction examination, but most of these are not extreme cases. Many of them will return to their jobs without psychiatric help. Some of these are rejected specifically for the task of soldiering, and they get along quite well as civilians. Others will continue to live warped lives, never realizing a reasonable return on their potential and yet not knowing exactly why. Others will seek help but will not find it. In many cases the Selective Service Board and Induction Station will be the only agencies that have a record of the disability.

The importance of good selection for the Armed Forces is revealed in a study by Hunt.[3] He investigated 537 marginal psychiatric cases in which the men nevertheless were able to complete their service. These men were hospitalized for nonpsychiatric conditions eleven times as often as the normal. They were involved in disciplinary difficulties three times as often. Their offenses were chiefly AWOL, alcoholism, and insubordination. Time lost for AWOL was thirteen times that of the normal. However, good selection is not a complete solution. The latency of mental disorders, the fact that the armed services deviate so far from normal life as a mode of living, and the fact that adverse psychological factors may bear upon the man after induction all require that psychiatric vigilance never cease. Studies by Brill and Beebe [4] have shown that half the neuropsychiatric casualties could not have been anticipated before induction.

The statistics on mental disorder in cases of premature separation are subject to distorting influences, so that they cannot be taken at face value. For example, it is easier to expedite separation if a serious psychiatric diagnosis is recorded. Also the discharge of disciplinary cases may be facilitated if a medical rather than an administrative reason is stated.

THE ARMED FORCES

The next step for the man who has been declared by the examining station to be qualified for military service is induction into the Armed

Forces. The mental health activities of these forces are constantly being changed in the effort to improve them. For example, as of 1955, the Navy, Air Force, and Marines were accepting only those who volunteered prior to reporting for induction. The picture at any one time nevertheless reveals the essentials.

All three services recognize that preinduction selection is far from adequate and that evaluation and selection must continue during basic training. In fact enlisted men are admitted now more liberally than in the past. The clinical units discussed below are especially valuable in this evaluation which may either weed out or select in. The Navy is continuously conducting psychiatric research in the effort to improve the accuracy of its selection, and the medical services of each of the forces include a division of psychology which is concerned with both research and clinical service. Each incoming recruit is interviewed by the psychiatrist, and in questionable cases he is seen periodically. Mental illnesses beginning early in this period are apt to be considered as non-service-connected.

The Armed Forces also recognize that the shift from civilian to military life is so abrupt and drastic as to endanger mental health and that they must make psychiatric service readily available at all times. The strain of this transition shows up in 5 to 10% of the men and is revealed by illness, maladjustment, poor performance, enuresis, learning problems, and misbehavior. The Army has found that only 6% of the eventual cases of schizophrenia appear during the first month. The illiterate group is especially vulnerable to emotional disorder and so is given prompt minimal teaching. Psychoses tend to string out throughout the duration of service without great concentration at any point. Their incidence is less than three cases per mean 1,000 troops per year. Psychological services are mobilized to assess the capacities of all recruits in order that the best use may be made of their talents and the mental hazard of misplacement reduced to a minimum.

Mental Hygiene Clinics. The training centers and especially the basic training centers of the armed forces maintain mental hygiene and psychiatric outpatient units. These are staffed with psychiatrists, psychologists, and psychiatric social workers. This staff works individually as well as in team, depending on the needs of the case. Psychological evaluations are especially depended on in making reassignments. Patients are referred by any of the training staff but mainly by those who deal with disciplinary problems, the chaplains, and the Red Cross. The findings of these units may lead to treatment within the unit, to disposition in the case of disciplinary cases, or if necessary to transfer to a hospital.

These units serve a preventive as well as clinical purpose. The clinical reports not only serve to assist with a particular case but help those who refer patients to sense the mental health problems of the serviceman and to deal promptly and more effectively with them. In many centers the staff of the unit takes part in the indoctrination and training of line personnel with the intent of developing a better appreciation of incipient disorders. Such training has now been introduced into the curriculum of the United States Naval Academy, where the same personnel provide both education and clinical service.

The study of the patients brings the clinical personnel into close touch with all aspects of the training center. It enables the unit to discover conditions in the center, or the community, that are prejudicial to mental health so that these conditions can be reported to appropriate authorities. In fact the unit is on the alert for signals of these conditions such as unauthorized absence and venereal disease. The emotional disturbance of patients proclaims most loudly the failures of morale, incentive, and motivation and the factors that contribute to them.

Some idea of the effectiveness of this prompt clinical and preventive work is given by the fact that in the Army 20,500 out of 22,000 patients seen in one year were returned to duty and that there was less need of hospitalization. The incidence of psychiatric discharges has fallen by 65% and the unfitness discharges by 80%, in spite of more liberal criteria of selection. The treatment of psychiatric patients is supported by using certain nonmedical facilities which are otherwise employed for the more positive purpose of building up the normal serviceman's effectiveness, e.g., athletics, marches, education, and recreation.

While the psychiatrist's duty to the man who is being discharged does not include protracted treatment, it does call for the most concentrated use of his skill not only to give the serviceman maximum benefit and return him to a more favorable civilian setting as soon as possible, but to reduce his disability claim to a minimum and thus serve the interests of the whole public as well. Through Red Cross the patient is given advice and specific assistance in securing treatment and such other help as may help restore him as fully as possible as a responsible civilian.

Psychiatric Hospitalization. The armed services maintain psychiatric-hospital units at important centers in the United States. These provide both closed- and open-ward treatment. Most of the closed-ward patients are destined to return to civilian life, although only a small portion are sick enough to need hospitalization in their home communities once the pressures of military life have been lifted. However, the Navy tends to transfer a patient more promptly to a veterans' hospital once his military unsuitability is established. The most common illness among the closed-ward cases is a form of acute schizophrenia which responds well to early intensive treatment, but many patients have character disorders on account of which they have not been easily amenable to discipline.

Some hospitals are primarily for diagnosis and brief intensive treatment. Many of their patients are expected to return to duty. If a patient in such a hospital needs extended treatment and disposition, he is transferred to another general hospital which has a psychiatric service designed for such treatment.

Service in Combat Areas. At no other points is the mental health of the serviceman who completes training put to as severe a test as in combat. His training was designed to build up his capacity to withstand this stress. But for some this preparation will have been insufficient. The duration and severity of combat may tear down the man's reserve and turn him into a psychiatric casualty. The first bulwark of the emotionally disturbed soldier is his own combat unit. Both line and noncommissioned officers of these units are trained to render psychiatric first aid, and this is enough in many cases to restore the man to full effectiveness.

The tendency in the Armed Forces is to bring treatment to the serviceman at the earliest possible moment of need. Accordingly these treatment services have moved closer to forward areas of combat. By providing treatment at the beginning of emotional disorder the chances of chronicity are much reduced. Only where the prospects of the man's success in the forward area are dim is he moved further back. But even here the emphasis is on his return to his outfit as quickly as possible. The Navy has found that less than 10% of all psychiatric referrals have had to be evacuated to the United States and that less than 10% of these who returned to duty had to be readmitted for mental disorder. Ninety-six per cent of the psychiatric admissions were off the sick list in 15 days. In the Army in about 60% of cases this is successful. These patients suffer primarily from fatigue, exhaustion, and exposure and respond well to removal of these causes. However, there are less favorable cases of psychoses and malingering. As it becomes necessary to move the patient further back from the area of combat, the prospect of return to his combat unit decreases. Some who cannot return are salvaged for noncombat duty. Others go on to discharge. At each of these successively more distant hospitals there are also noncombat casualties who come from among the men who have not yet reached the combat area.

A factor in all combat cases is battle fear. This factor is counteracted by shortening the period of exposure to danger and providing periods of rest and recuperation. In addition there is individual hardening, the building up of group spirit, and care that the leaders are men of understanding. As in the training period, so in combat areas those who study the psychological casualty are in a position to sense danger signals, and to educate others to detect problems and dangers and to know what to do about them.

Mental Hygiene. The psychiatric outpatient and inpatient services of the Armed Forces perform other duties than direct service to patients. They participate in training of other personnel who must help the serviceman make his adjustment. They detect and help remove hazards to mental health. They assist administrative boards, courts-martial, those responsible for discharge, those who are dealing with prisoners, and those who are reconditioning men either for discharge or for return to duty. Some carry on research. The military psychologist contributes especially to the evaluation of personnel looking toward the maximum use of assets. Since every phase of military life has its impact on morale, the psychiatric and psychological personnel have constantly to take this implication of their work into account. They must be careful that their services are identified with return to duty rather than discharge. Even a man with epilepsy may, by medication and wise placement, be rendered useful. Precautions must be taken that an emotionally disturbed man does not weaken the morale of his group. Since commands which have poor morale have a higher psychiatric casualty rate, those who treat patients and measure the assets of the men and their progress in training are able to identify these units of low morale. On occasion the mental health staff must help dependents of the serviceman in order that their anxieties may not undermine him.

Reference has already been made to the function of the psychiatric and psychological personnel in training and consulting with line officers. This assistance not only is preventive but helps overcome the officers' tendency to delay action until the case is aggravated. Then treatment is likely to be long, expensive, and difficult if not futile to the point of permanent disability and compensation.

In addition the clinical facilities are used for the training of mental health personnel themselves. The Army designates three of its hospitals for the training of psychiatrists, psychology technicians, social work technicians, neuropsychiatric technicians, general medical officers, and psychiatric nurses. The Navy uses four of its hospitals for psychiatric training. While the purpose of these training centers is to assure a continuous supply of competent personnel, they have become an important source of supply for civilian purposes as well, since most of the trainees return to civilian practice.

The research function of the armed services is similarly motivated toward the mission of military success. But the research findings have general value outside the service. By the same token other Federal and civilian agencies contribute by research to the needs of the Armed Forces. Mental health research includes studies and experiments in personnel assessment, environmental impact on mental health, sound assignment of personnel, use of mentally handicapped personnel, improvement in training, utilization of all personnel in the interests of mental health, proper location of psychiatric facilities, and the effect of cultural and social factors on mental health. Some of this research is conducted within the services; some is carried out by contract with civilian agencies.

An important part of the mental health work of the Armed Forces is to deal with character and behavior disorders. To this end mental health personnel serve as consultants to courts martial and to administrative boards concerned with the adjudication of disciplinary cases.

Psychiatric Services at the Disciplinary Barracks. The Army has a prison population of approximately 1,500. For these there is a staff of psychiatrists, clinical psychologists, and psychiatric social workers and technicians. Each prisoner is examined, classified, and treated by this team, and facts pertinent to clemency are clarified. They also aid in his rehabilitation. In this they do better in general than civilian correctional facilities. The study of disciplinary cases helps to clarify psychological weaknesses that might better be taken into account in selection. The retraining service of the Navy warrants special attention:[5]

> The objectives of the retraining command are two-fold: The primary task is to salvage the maximum number of these offenders for future Naval service and

secondly, where this is clearly impossible, the command endeavors to maximize the individual's chances for a conforming and productive civilian existence. From the moment a man arrives at the retraining center the psychiatric service makes every effort to foster his personal growth and maturity. The task is to free the man as quickly as possible from his personality and emotional disturbance so that he can initiate his own restoration plans. The psychiatrist and psychologist assist the individual with an extensive therapeutic program consisting of individual and group psychotherapy, orientation films and lectures, on-the-job training, adult education courses and occupational and vocational counseling; all aimed at helping the retrainee decide what he wants to do in his present situation to better prepare himself for life in or out of the service.

The rehabilitation training centers of the Army serve a similar purpose.

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21 MENTAL HEALTH AND WORK

Those who are occupied with mental health have been so preoccupied with either the mentally ill or the protection of the mental health of the child that they have given little attention to other large blocks of the life span, especially the workaday life. Since positive mental health comes with the use of one's talents, the relation of work to mental health is obvious. The satisfaction that one feels when he is using his creative capacities is a signal of positive mental health. One has only to see the pride with which a skilled workman puts the finishing touches on his product—beyond the call of the specifications—to be convinced that the value of the product is not wholly intrinsic. By this same token it is clear how much he loses when the limitations of his work do not allow for these finishing touches. The question may properly be raised whether the frustrations of a task that does not eventuate in a visible finished product are not disorganizing and contributory to awkwardness and accidents.

MENTAL HEALTH ASPECTS OF WORK

Weinerman[1] stipulates some conditions for mentally healthy work, including (1) a meaningful relation between one's job and his social needs; (2) a combined use of physical and mental abilities; (3) a personal interest in his product; (4) job safety; (5) work that is in keeping with his talents and training that will help him to use them; (6) protection against sickness, unemployment, and old age; and (7) democratic participation by the worker in his job.

Differently stated, he wants his job to be satisfying in keeping with his talents. He wants it to give him security of tenure. He wants to be considered essential. He wants to be paid adequately for his work and to know that he can move ahead as far as his talents can be used. The physical conditions under which he works may be excellent, but if the psychological climate is oppressive or unappreciative he is likely to be disturbed and fail to serve as a fully effective member of the working team. The way he works, with zest or with an eye on the clock, therefore, becomes a measure of his mental health and either a help or hindrance to his further vocational progress.

The virtue in work is pointed up by Paul Cornil[2] speaking for Belgium before the United Nations Secretariat on prison labor: "Work was a privilege and not a punishment; to imprison a person without recognizing his right to work was tantamount to increasing his sentence. . . . There was in fact no need to apply the principle of obligation, save in the minority of neurotic cases, when other treatment was more appropriate." The virtue in work is thus inherent in the healthy worker and not in the work. This concept of work is quite different from the puritanical idea that work is virtue in itself whether it is expressive of one's talents or not, or whether it is satisfying or drudgery. Work thus conceived could be a bitter pill. That kind of work is sackcloth to be suffered for its capacity to callous the sensibilities (talents) and to "build character," i.e., stolidity. Satan finds unwholesome work for idle hands to do only because those idle hands have had their capacity for creative work dulled. An inner potential no longer prods them to creative satisfying work. Sensitive busy hands that are not carrying out one's potential are exasperated and apt to be rebellious. As expressed by Fallett,[3] "Scientists, philosophers and psychologists . . . are coming to agree on a very fundamental principle . . . that the essential nature of a unity is discovered not alone by a study of its separate elements but also by observing how the elements interact."

The dignity of work is emphasized repeatedly as an essential of mental health. But the dignity of work is not entirely inherent. It is determined also by the social status of the job. The homemaker may well wonder if her work is dignified. The employment status of the United States population as of the census of 1950 is reported by the 1954 World Almanac in one of two categories. The labor force includes some sixty million, of whom nearly three million are unemployed. But the thirty-two million housewives and others "keeping house" are grouped with those unable to work, inmates of institutions, the immature, and the superannuated. Still it is to a great extent upon the homemaker that the mental health of a nation depends.

DEVELOPMENT OF VOCATIONAL POTENTIALS

It is the task of the family and school to help one to find his place as a mentally healthy worker motivated creatively toward an end product rather than mere jobholding or drudgery. If the home and school are successful in developing the child, he will later employ some of his skills in the main vocation from which he derives his livelihood. He will use other skills for pleasure apart from any other profit, i.e., as an avocation.

The first job in one's life is a big event for most people. It is the sign that the dependent, growing-up period is giving way to the use of one's powers for social as well as personal gain. The exercise of a talent primarily to train it (schooling) gives way in the real job to productive and creative use. The measure of success for the emotionally mature person is no longer his ability to pass a school test or to satisfy a teacher or a parent. It is no longer a mark or grade. The talent is now used to create something which symbolizes and realizes his own self.

In many communities public or private employment services give special help to youth in planning their careers, in getting specific training, and in finding jobs that are suited to their attitudes. They are potentially important mental health agencies. Some of them include psychological services for the discovery of vocational aptitudes. A good example of a private nonprofit agency set up to provide advice is the Vocational Advisory Service[4] in New York.

The abruptness of the transition from school to work varies widely from culture to culture. In many parts of the world the girl steps into her adult domestic role hardly cognizant of a change, for she has already put her domestic talents to use in her parents' home even while she was still exercising and developing her skills. The transition to adult responsibilities is graduated also, since the care of her first baby may be shared with the older women in the family. She may in turn be so used to caring for the younger children in the family that the coming of her own baby finds her well prepared.

The abruptness of the transition may also be reduced when adult work has been preceded by a period of serious part-time work. In migrant agricultural families, children often take part in the family labor from an early age. Also many children leave school early and go to work because the school has not discovered and cultivated their particular abilities and capacities. It offers no incentive for the child to stay in school. Work can be of positive value if it is conceived as a force in the child's development and is freed of danger and exploitation. It is for the safety of such children that the National Child Labor Committee and the Federal Department of Labor sponsor child labor regulations. In fact the former has a special interest in promoting the positive aspects of work as well as guarding against the negative ones. Unfortunately it has not always seemed possible to set up regulations to protect children without restricting some for whom work might be educative and constructive. It is the children whose talents are most limited, i.e., the mentally retarded and mentally deficient, who are given the least help in making the transition to work life. Still their meager talents need especially to be conserved. Fortunately the working world often gives them more choice for using their potential than does the school.

The National Advisory Council on State and Local Action for Children and Youth, a quasi-governmental council of state representatives, has given special attention to the transition from school to work. This Council suggests 17 ways in which youth may be prepared for the change. It suggests that help be given in finding summer and part-time jobs, in appreciating the dignity of work, and in understanding their capabilities and the jobs that correspond with them. It suggests good supervision and job counseling. It urges that teachers be relieved of overload so that they can give pupils individual attention, deal with their maladjustments, and relieve them of the need to choose a job for financial reasons only. It stresses the need for special attention to the occupationally handicapped, i.e., the children of minority groups, the juvenile delinquent, and the mentally deficient. This same Council suggests ways of overcoming the problems faced by migrants.

INDUSTRIAL WORK

Much that has been written about work and mental health has been concerned with work in large industry. This is understandable, for it is the larger industries that are able to afford professional personnel staff.

Over a quarter of the labor force of the country is employed in industries which are so large as to call for special facilities to adjust the limitations of the workers to the demands of the business. Some industries are quite successful in this reconciliation. Others, however, consider a worker expendable and thereby override human and cultural values with disturbing effects. But most workers do not fall into this category. They include housewives, farmers, small merchants, and workers in small plants. These workers are more apt to find work suited to their interests or are freer to adjust their work to their potential. When a job is part of a large human mechanism, it regiments, follows routines, provides no opportunity for initiative, and is so remote from the end product as to lack a creative quality. Such work contributes less to mental health. However, this kind of work cannot be avoided, for it is a part of our national fabric. This means that many workers must obtain their creative satisfaction elsewhere in life. The next chapter on recreation deals with one form of compensating activity. Where there is no balance for the psychological sterility of a job, psychosomatic disorders and accidents may be expected to rise. The psychological hazards in industry are usually less evident than the physical. Also their effects vary so from case to case that it is hard to generalize about them. Noise, for example, may produce tension and sleeplessness in one person and affect another quite differently. Even when psychological hazards are known, the complexity of a working situation may be such that they are hard to eliminate.

There are some who would reduce the danger of mental casualties in industry by regimenting the worker simply to remove his uncertainties. They do not appreciate what positive values are lost by this policy. They forget that in a democratic culture there are values that transcend even the avoidance of mental disorder. If the only safeguard that is offered against the frustrating effect of a job is regimentation, it is a questionable bargain. Henry J. Brides,[5] President of the Massachusetts Federation of Labor, makes a point of this: "We recognize that consciously or subconsciously, human nature reacts against this monotony. It reacts with restlessness, frustration and 'lack of belonging' on the part of the individual. . . . These problems, affecting mental well-being and even physical health, can cause a tremendous loss of efficiency in social and occupational performance." On the part of management[6] this respect for the person is expressed as follows: "Good human relations within the enterprise . . . will not only permit the individual to achieve the best economic growth but will help him to attain a higher degree of spiritual development."

Any efforts to advance mental health in industry, if they are to succeed, should involve both management and the employees. This is not to imply that the two interests are essentially opposed, for they are not. It is no gain to an employee to be invalided no matter what his compensation. Nor does it further the purposes of industry to lose the services of a worker and the investment in his training and still have to pay him. The investment in a worker includes not only the cost of teaching him a skill but also that of training him to be a member of the working team. The farther up the line of authority the casualty occurs, the more serious the loss and the more difficult it is to make a replacement, for the team becomes more complex and involves more persons.

Collins [7] has pointed out that 30% of the manpower loss of industry is due to emotional disturbance. This figure is undoubtedly minimal, since it cannot include the immeasurable losses in productivity and the handicapping of teammates when the emotionally disturbed worker is still on the job. Of course any phase of the worker's life may contribute to these emotional disturbances; they cannot categorically be attributed to working conditions. By the same token services designed to treat these conditions cannot be expected to succeed if they are not equipped to take outside factors into account. Also too often these services focus exclusively on the worker's illness and tend to invalid him, whereas he may still have assets for work which he could be helped to use.

The work of Elton Mayo [8] and Roethlisberger [9] has done much to clarify the principles involved in the mental health of the worker. Psychological techniques have been developed for the assessment, classification, counseling, selection, and assignment of personnel and have been of service to both management and labor. Many industries employ psychologists to aid in the selection of personnel and in the identification, assessment, and promotion of motivating forces. They also serve as counselors in employee-management relations and effective processes of supervision. Some industries now contract for regular psychological services to help them analyze and deal with their personnel problems.

Very few industries have well-developed psychiatric services. Such as exist are chiefly concerned with personnel who have already become sick. The psychiatrist's task in industry has been well developed in a report by the Group for the Advancement of Psychiatry.[10] While the treatment of mental disorders can be made more personal and dramatic than positive mental health and prevention, these latter are industry's greatest mental health opportunity. They concern industry not as an altruistic service to its employees, but because they contribute to the success of the business itself. Some psychiatrists and psychologists have pursued prevention along with their other functions. By tracing the cases of failure back to their causes they have been able to detect and neutralize factors that affect the adjustment of all employees. The emotional breakdown in this way becomes a signal that conditions within the industry are in need of attention. The supervisor is seen to be in an especially crucial position, for when he himself suffers an emotional disturbance its influence is likely to be passed on to his subordinates. Conversely when several members of a team show evidence of emotional disturbance or reduced effectiveness, it is now the rule to look for some disturbance in the higher-ups.

Menninger and Levinson,[11] drawing on many authorities, point to absenteeism, accidents, and alcoholism as the signals of underlying faults in all industries. Only 5% of absenteeism is due to on-the-job causes. This is shown by the fact that one-third of the workers account for three-fourths of the absences. Absenteeism tends to be chronic and is just one expression of a total social maladjustment. The maladjusted employee, even when working, is low in efficiency and disruptive to coworkers. Accidents are also largely dependent on psychological causes, so-called accident proneness. According to McLean,[12] in the middle 1920s it was demonstrated that the more accidents a man had in the past, the more likely he is to have an accident in the future. It is estimated that 2% of employees are problem drinkers, and many of these are employees in whom the company has made a great investment.

It is often more difficult to deal with unwholesome attitudes in those who are in higher authority than in the rank and file. Executives, especially those who are climbing, are reluctant to admit any defect that may seem to mar their personal records. It is, therefore, a wise preventive measure to take mental health into account in the selection and training of executives of both industry and unions. It is not always realized that mental health may be jeopardized just as much by advancement beyond one's capacity as by the suppression of opportunity for using one's talents. The total effect may, in fact, be more serious, because the subordinates of one who is unduly promoted suffer the impact of his anxieties. In spite of brilliant work which has been done in protecting and elevating the mental health of employees, there is still but a token provision by industry for this form of health work.

Felton,[13] with an eye on prevention, has emphasized the importance of determining in advance of employment or promotion whether a candidate is emotionally stable. Also during an initial period of orientation new employees may be given information about special mental hazards in their work. Such safety education is in fact appropriate for all employees periodically. Many times an initial evaluation will show the need for a special assignment in order to preserve the valuable potential of an emotionally fragile employee.

It might be supposed that the finest of occupational mental hygiene would be found in mental institutions, which include psychiatrists and psychologists in positions of highest authority. But the complexities of administration are such that this is not generally the case. Administration is too often authoritarian. Also employees are often stratified socially according to their professions and salaries. Living conditions, especially for a family, leave much to be desired. Likewise social security, workmen's compensation, working hours, housing, food and safety, sick leave, vacations, recreation, and adjustment of grievances have tended to lag behind those in industry.

UNEMPLOYMENT

Unemployment is certainly not a condition to be encouraged, yet it has its compensations which are essentially good. During unemployment people can at last do things they have always wanted to do. These compensations, however, can be seductive to the point of weakening the will to work for those whose regular work is drudgery.

On the negative side unemployment in our culture is an immense stress on a man's ego. He is likely to feel quite disgraced before his family and a failure before society and not infrequently resorts to alcohol as an anesthetic to ease these pangs.

Many states have sought to balance the supply and demand for labor by establishing employment services whereby skilled counselors help clients to find suitable jobs. When executed by a well-trained staff this is an important mental health service, for it not only provides work but reconciles the work with individual capacities. Some of these states have established training courses for employment counselors in order that the psychological aspects of interviewing, evaluation, and job placement may be carried out skillfully. Unfortunately in most states neither the hospitals nor the employment services are equipped to meet the needs of the mentally handicapped. The significance of employment services to mental health is shown in the stated objectives of the U.S. Employment Services.[14] These serve as a measure of the mental health value of any employment service. This service provides "employment counseling to determine present and potential occupational abilities and interests of workers in the light of realistic information about job requirements and employment opportunities."

These employment services contribute especially to mental health when they help the handicapped, including mentally handicapped persons, to find suitable positions. The New York Employment Service uses a part-time consultant psychiatrist to advise the employment counselors and to participate in their training. In some communities in New York the state mental hospitals provide similar consultation. Consultants have, of course, first of all to acquaint themselves with the practical problems and processes of employment services. Hillside Hospital,[15] a private nonprofit mental hospital in New York City, has given special attention to the employment of its patients. That hospital has been impressed with the extent to which the lack of suitable work may contribute to the mental illness. With the help of the Federation of Jewish Philanthropies Employment Service, which offers many evaluative and adjustment services, this hospital has been able to place some of its most difficult cases. According to this hospital, "too frequently . . . patients . . . have returned to . . . conditions which occasioned the original illness." It also stresses the value of a sheltered workshop as an aid in the transition of the former patient to the normal stream of occupational life in the community.

It is an unfortunate reflection on the adequacy of a state or community psychiatric service when an employment service must itself diagnose and treat the mentally handicapped whom it is trying to place in jobs. It is equally unfortunate when a hospital or clinic is forced to muddle along giving employment service to its patients. It is not rare for hospitals to encourage patients to conceal their problems so that they can get jobs. Good employment services know that this is not good for the client and alienates friendly employers. Physicians often recommend farm work for patients without a clear appreciation of what such employment entails. Often a former hospital patient is not really ready for employment. He has only partially recovered. He needs further treatment. Many patients are wisely discharged from the hospital when they are good social risks but not entirely ready for employment. Unless this fact is known to the counselor he is apt to deal with the client as a normal placement when he is in need of special consideration. In such a case an employment service may use valuable resources and test the good will of employers in doggedly trying to "sell" a prospect who is not ready for a job. Very few states seem to recognize the need for teamwork between the psychiatric and employment authorities.

In New York State 3½% of the clients of the state employment service are handicapped, about 650 per week being frankly neuropsychiatric cases. This does not include the cases that come to light among the unsuccessful efforts at placement of the supposedly normal. For even where there is no obvious mental disability the repeated failures in job placement are usually due either to an obscure mental disturbance or to poor interviewing and counseling. At the same time 3.8% of their placements are handicapped persons, indicating a high degree of success in the placement of the handicapped.

There is need for research in this field in order that the causes of failure may be better understood and the techniques used in the services may be improved. Also there is need to inform the public about their employment services so that they will understand their value and needs and provide better support. There is also need for teamwork between the mental hospital and employment services.

RETIREMENT

Just as the transition from school to work is critical in youth, so is the reverse transition from work to retirement in later years. The person with unrealized personal abilities who has not been dulled by routine and drudgery may be able after retirement to give freer rein to his talents. Sometimes, as with Grandma Moses, this may become the most creative and satisfying period of life. Under these conditions work becomes indistinguishable from recreation. But for persons of lesser resources, persons whose ambition has dried up, there may be neither work nor recreation in the time-biding activities that anticipate only demise. These persons need help. As expressed by Loeb,[16] "By the time of retirement and the grand-parental period of being rejected from family life activity, this value —saving for the future—is so internalized that older people cannot use what resources they have for the present gratifications. They still must put off." Such persons may be in no special danger of mental illness, but neither have they any promise of a positive mental health, i.e., the zest of living and expressing their potential. Some communities act as if old people were of importance only to the nursing home and mortician. Contrariwise there is a continuous opportunity to further a positive mental health through work literally from the cradle onward.

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22 MENTAL HEALTH AND RECREATION

It was pointed out in the preceding chapter that recreation and work are often complementary. In fact the two are sometimes not clearly distinguishable. Some people find in their work such complete opportunity to use their talents that it is continuously recreative and adequately satisfying. Similarly others become so skilled at their play that it becomes their vocation, e.g., professional baseball players. Many persons have found their hobbies both recreative and profitable. This is simply a concrete evidence of the well-established principle that a healthy man is the well-integrated man. This principle is as ancient as the word "health," which found its origin in common with the word "whole." By this same principle recreation meshes with education, family life, and religion. Which are the dance and the drama—play or ritual? The type of rearing which children receive among certain peoples is reported[1] to correlate with the occurrence of drama in their culture.

NATURE AND RELATIONSHIP OF RECREATION

One cannot read the 1954 Yearbook[2] of the American Association for Health, Physical Education and Recreation without sensing the breadth of perspective and inseparability of these fields from the whole of education, family life, value systems, and other customs. Physical education seems to stand in a midway position between recreation and education and is identified with both. Physical education is usually thought of as concentrating on the development of large muscles. But this distinction is arbitrary, for it is true, even if it is not so obvious, that much of general education is also basically muscular education and development. Reading, writing, speaking, hearing, and even apparently abstract thinking depend upon the refinement of neuromuscular functions. It is generally known that emotional disturbances affect the coordination of small muscles, especially those of speech.

To the extent that life is regimented there is need to provide an opportunity for the expression of one's potentialities quite apart from the so-called "serious" undertakings. To serve this purpose recreation cannot also be regimented. It must be spontaneous. It cannot be imposed. It cannot be strained. Its spontaneous quality is the best guarantee that it expresses the needs of the person. But some people have been so constrained by the rigidity of the situation in which they have grown up or have become so restrained by their own anxieties regarding what they are free to do or not to do or by inconsistencies in their surroundings that they do not know how to act when restrictions are not imposed. They need help and encouragement in order to reach the point where they can express themselves spontaneously, and the earlier this help comes into their lives the less resistance will they need to overcome. Some find this help by beginning with predesigned or formalized recreation, for on the one hand, it has social sanction, and on the other, it allows a modicum of self-expression. Some persons, especially younger ones in whom restraint and constraint have not been so severe and enduring as to produce unchangeable effects on the character, can overcome their lack of spontaneity if appropriate degrees of partial permissiveness are offered gradually. Some can play more freely if their recreation is solitary rather than in a group or a team.

Since the values of recreation are not as obvious or measurable as those of work in the value system which prevails in the United States, it is not rated as one of the "serious" functions of man. It is instead apt to be thought of as trivial or frivolous, a way of merely passing time. It is often identified with the irresponsibility of childhood. It is perhaps the persistence of puritanical values that perpetuates this antithesis of work and play. Still the play of many young mammals is found so consistently as to warrant its being taken seriously as an essential part of the economy of growing and living. This animal play looks like fun, and as far as we know, it is. But at the same time it is a part of growing up.

The recreational interests of two people may be superficially similar and yet worlds apart. One may be engaged actively and another only passively as a spectator. Often what appears to be passive is, however, in fact far from it. The audience at any baseball or football game is obviously more than passive. In fact passive recreation is a play of emotions and tensions quite in contrast to the muscular coordination of large muscles of the active participants. The teamwork between players and spectators is much more real than it seems to be on the surface, as shown when it is formalized into cheering sections, cheer leaders, and applause. In any case passive recreation is resorted to more and more with advancing age, especially with the encouragement of radio and television.

Recreational activities of a solitary nature, such as stamp collecting, engage many persons of sound mental health. But because they make a minimum demand for social adjustment and require little teamwork they are apt to attract and absorb also those who do not easily fit in socially. One may find a similar distinction between those who enjoy individual sports, such as track and field sports, and those who are attracted by team play.

A corollary task of recreational leadership is to sense the problem case and to offer first aid, to know where help can be secured, and to know how to guide the fragile person to an individual service. There is need to recognize that such a person may have succeeded in establishing a relationship to a group worker only with great emotional effort and that he may need a helping hand in making a new approach to another agency to which he is referred.

The training offered by schools of social work and such organizations as the YMCA is more and more taking these functions into account. During the war some of the staff of the United Service Organization found that they were in a position first to sense the problems of soldiers who were in emotional difficulties. Under the more permissive atmosphere of USO these soldiers were able to relax and reveal their needs. A recreational agency has an opportunity to help the emotionally disturbed which if followed up skillfully can be of great social value.

MENTAL HEALTH PROBLEMS OF RECREATION

Not realizing the importance of play as an educative process, school boards often fail to authorize the facilities and the personnel that are needed by the child in order that he may play. It was brought out in the 1930 White House Conference[3] that children who grow up in modern apartment houses with small indoor space and without outdoor play facilities are confronted with a most serious handicap to their healthy psychological growth. Certain types of recreation provide exceptional opportunity for the development and use of one's social potential. Through team play one comes to understand others better and learns how to relate to them.

Perhaps a distinction has to be made between entertainment and recreation. The origin of the word entertain, "to hold between," is much more closely related to the biding of leisure time than is the word recreation. In fact, Webster defines "entertain" as to "engage the attention of agreeably, to amuse with that which makes the time pass pleasantly, to divert."

Still one may be misled by judging the recreative value of any activity by its appearance. Only its meaning to the participant can reveal how recreational it is. What is recreation to one person may be an addiction or the expression of an underlying mental disturbance in another. A sport fan may become literally bedridden if his favored team fails at a critical moment. Competition for one person may be a pacemaker for the fullest development of his potential. To another it may be a vehicle of hostility, or a way of proving he is not inferior. The latter reaction to competition may be far from recreative in that it may lead to unfairness rather than the expression of useful and satisfying potential. Team play may help some to express and build up a capacity for social interdependence and respect, or it may train others to use their teammates as steppingstones toward a purely selfish goal, as in playing to the grandstand. Passive recreation may be a useful emotional stimulus for the aged whose zest for more active recreation has shrunken or whose decrepitude prevents more active pursuits. But passive recreation may be questionable in children and young adults when it largely replaces activities. The disadvantage of addiction to television lies not so much in the shallowness of the content of the programs as in the pauperization of creative capacity of the child and the restrictions of his social experience. This form of addiction, like any other, constitutes a retreat from real life and may be symptomatic of an existing impairment of mental health.

Recreational services are too often overformal. It is paradoxical to regiment recreation. Each person is different—different as to his potential, and different as to the satisfactions which he can derive from any particular form of activity. It is not uncommon to find the devotee of a certain type of recreation urge it upon another. A parent may be quite disappointed that his enthusiasm for athletics, fishing, hunting, etc., is not shared by his child. Still it is a measure of one's mental health to be able to accept different likes and dislikes among his friends and relatives. Two persons may have a close emotional tie and still be unable to join in all their recreational pursuits.

NATIONAL LEADERSHIP

The National Recreation Association [4] is the national voluntary organization which gives leadership and counsel in this field. Its monthly periodical, *Recreation,* presents articles from time to time dealing with mental health.

It is unfortunate that organized recreation does not more readily identify the cases of mental deviation among its clients. Truly it should not be expected to know as much about its clients as a case-working agency. However, there is need for more professional training to sensitize the recreation worker to evidences of mental deviation, to know how to employ his skills and resources to help the exceptional case and to call in other agencies when needed. There is a tendency, deplored by recreation leaders, for recreational agencies to focus too exclusively on the normal. As a result they fail to attract or fail to hold the timid, anxious person who needs the help of recreation even more than the normal. Many emotionally disturbed persons strive repeatedly to identify themselves with normal groups only to find that there is no satisfying creative opportunity which is suited to their interests, or at least their lack of aggressiveness. In the beginning they find a competitive situation too threatening to endure and so move on to less social pursuits.

NOTES

1. Mead, Margaret: "Age Patterning in Personality Development," *American Journal of Orthopsychiatry,* 17:231–240, April, 1947.
2. *Children in Focus,* 1954 Yearbook, American Association for Health, Physical Education and Recreation.
3. *Official Proceedings,* White House Conference on Child Health and Protection, Nov. 19–22, 1930.
4. National Recreation Association, 315 Fourth Avenue, New York.

PART FIVE

Special Considerations

23 PROGRAM EXECUTION AND SOCIAL ACTION

In Chapter 2 suggestions were offered to put program planning on a more certain and designed basis. In the chapters that followed a perspective was given on the total range of potential program from which, according to criteria of priority, the actual program might be selected. Now, having decided on the program, the next step is to begin to carry it out. There are many hidden forces that can help or hinder the execution of the program. These forces and the things that may be done to identify and use them constructively are the subject of this chapter. If one hopes to improve unsatisfactory conditions, he should know the forces that give rise to existing conditions, the forces that perpetuate them, and the forces that must be considered in making change. If any one of these forces is ignored, plans otherwise well laid may prove ineffective.

FORCES AFFECTING PROGRESS

Among these forces is the very character of institutions. If social institutions are to be changed most expeditiously on behalf of those whom they serve, then the social institution as a phenomenon as well as the specific agency must be studied and understood.

Isolation. To this end it is well to remember that it is characteristic of an institution that it resists change. That, in fact, is the meaning of the word and is a part of the social value of an institution. But in order to resist change it tends also to isolate itself and makes very limited contact with the community that it serves, even if it is in the heart of the community. This isolation obstructs the solution of many of its problems, especially since the society in which it sets is in constant change. But this isolation should not blind us to the fact that the institution is actually an integral part of the whole social structure and has a relation to it, even if the relation is one of avoidance. Isolation is in itself a dynamic relationship. When it cannot be achieved by geographical separation it is obtained by psychological means. The personnel build a resistance to the impact of imposed ideas. If the institution is isolated from the rest of the community, there is also a mutual seclusion. The institution lives the simpler life, off by itself, inured to a routine, unworried about a fuller concept of its potential; and the community lives a more comfortable life, feeling guiltless about the defects of their institution.

At the same time this adjustment in isolation is never static, never final. Times and conditions constantly change. This demands a constant readjustment, a new balance between the institution and the rest of the community. This balance still tends to keep them apart. For example, when Selective Service during World War II made conscientious objectors available as attendants to mental hospitals some state hospitals offered "good reasons" for avoiding these foreign entanglements. They did the same thing when Congress extended vocational training to the mentally handicapped.

This constant demand for readjustment provides an opening to break into isolation, and so when conscientious objectors and vocational rehabilitation became available some hospitals because of the times or their leadership were able to reduce their isolation. The institution is never really frozen, and it is its constant change that opens the way for improvements. Those who are promoting advances do well to choose the more fluid time and situation for their effort in order that they may be most effective. For example, county mental hospitals whose *raison d'être* is too often political patronage may be changed more easily when employment is high and patronage of little value. Since the status of any institution is the resultant of forces both inside and outside it, it is important to gain an understanding of the institutions and the community in which they exist. This is the purpose of a survey.

Origin. The survey should reveal the history of the institution, for its traditions are often a hidden barrier to progress. They are traditions not only of the institution's own concept of its role, but also of the community's concept of its role. As a rule the community agencies are begun for the purpose of meeting a rather limited social need. As knowledge and skill in meeting this need are increased, its role may broaden to include peripheral parts of the problem. If the institution can overcome its narrower tradition, these new parts are then incorporated into its role and the social institution grows. Take the schooling of children as an example. As life became more complex, it became more and more essential for people to be able to read and write. The initial step in meeting this need was to arrange for tutoring in reading and writing on a private basis. Eventually, as the need became universal, facilities in the form of public schools were developed. Then as the demand for knowledge broadened and as individual differences in capacities were clarified, the curriculum expanded and the classification of children became more complex. Some schools outgrew their three Rs traditions more promptly than others. Our other social institutions arose similarly from a community problem which served as an irritant. The early steps in dealing with a problem tend to be similar for all agencies. They are simple, direct, and minimal (palliative). An agency could under these conditions perform its expected role in isolation because its work was superficial. It did not attempt to get at underlying factors which would articulate it with other agencies.

Growth. The histories of agencies show that some grow up by adopting a responsibility for needs that previously were peripheral but closely related to their original purposes. By such expansion the gaps between agencies are closed. When an agency expands, its role comes closer to or overlaps that of others, and the possibility of working in isolation and without conflict is reduced. It becomes a part of the continuum of community services and can only artificially be bounded and separated from other parts. It is at these boundary lines that jurisdictional conflict is apt to arise, and while this conflict may be disagreeable, it is a sign of growth and can lead to a division of labor and collaboration. Some agencies are willing to expand, others grasp competitively for new territory (empire building), still others stubbornly resist new responsibilities. They seek comfortable isolation and avoid anything that complicates their administration. This antithesis of "empire building" is "administrative ease." Solid progress, therefore, usually depended upon deepening the functions of agencies rather than broadening them superficially. An agency that is concerned with dependent children then becomes preoccupied with the causes of family breakdown. The schools want to know why children do not learn or why they do not attend school. The physician wants to know why some patients make his treatment succeed, while others make it fail.

This growth of an agency into the depths of community problems produces interagency discomforts. It carries an agency from the familiar territory of its own field into scientific areas that are more or less strange to it. Yet the agency, beginning as it did within its professional field, often acts as if this new underlying territory were its own, too, even if it is technically different. The school, for example, may unjustifiably assume authority in the field of health or vice versa, although each, to be sure, can borrow from the other. It finds itself impinging upon the functions of other agencies, and conflict ensues until collaboration is worked out.

The statesman in mental health work realizes that he cannot progress far as long as other agencies that affect human living lag behind. His effort reflects a recognition of the integration of the person, an integration so complete that it resists his being torn apart. It, therefore, behooves those who are trying to advance mental health, if only in self-interest, to encourage progress in other aspects of human living. For example, a mental health association should not be content with a good active committee and program for the mental health of the aged. It must also release itself from the drag of laggard fields by encouraging other services to the aged in the community and must function as a partner with those other services. For the same reason mental health is better served when national, state, and local governmental departments and agencies that are concerned with human problems devise some mechanism which ensures their coordinate action. Such coordination is an appropriate intermediary objective for those interested in the ultimate goal of mental health.

An opposite tendency of agencies and disciplines is specialization, which tends to be narrowing. This is often the result of certain predilections of the staff rather than demands of the community. Specialization may reach a point where the mandate originally given to the institution by the community is altered without consent, leading to dissatisfaction. For example, in the early twenties Massachusetts established traveling clinics to meet the demands for service to the mentally deficient. Other places then adopted the clinic pattern of Massachusetts to serve not only the mentally deficient children, but children with emotional problems. As the techniques for handling emotional problems became more refined and intriguing and more promising of full restoration than those that deal with mental deficiency, clinics refused without community sanction in many places to serve the latter, even though there was no other service to meet the need.

Culture. Social institutions also differ for cultural reasons. While the needs of people are fairly uniform, there are differences in social structure and values which hasten or retard and shape the agencies that are set up to meet them. They determine how the direct, simple, and palliative service is carried out. These forces need to be known if progress is to be fostered; otherwise insistence on uniformity arouses resistance as being arbitrary, as it truly may be. There are, for example, appropriate differences in the curricula of schools as between an urban-mercantile community and a rural one. A community founded by immigrants from Germany tended to favor the teaching of the German language in its secondary schools, whereas one with a predominantly Italian background often chose Italian. The laws of Louisiana are based upon a different legal foundation than those of the other states because of its origin. In some countries medical practice as it is known in the United States may be divided among several professional groups. Psychotherapy, which is essentially a medical practice in this country, may be in different hands in another country. Since the social institutions are bound into and are an expression of the culture, it is appropriate that they differ from place to place. These differences need to be discovered and respected. Some differences run deep and resist change. Others can easily be modified. Standards can be "sold" only if they are flexible enough so that under them one can be comfortable that he is right in spite of the fact that another community sets up its institutions differently from his own—and is also right. "Familiar" is not synonymous with "right."

Load and Staff. While many things must be taken into account in a survey in order to understand an institution in relation to its community, two factors especially influence the quality of its work. The first of these is the load of work; the second, the adequacy of its personnel. Top-quality personnel are wasted and eventually lost when overloaded, and no growth can take place with a staff that is technically incompetent.

Readiness. The citizen who is interested in furthering mental health services has before him several considerations that will influence his choice. If the public is ready he may seek with some measure of assurance to try to develop services under public auspices. If not he may go far afield in emphasizing aspects of the work that are beyond the limit of public readiness, although it is safe to include a modicum of these things. For example, the public may be ready for the establishment of a service clinic, but not for a research program connected with it. If he wishes to go far beyond the limit of public readiness it may be necessary to combine public and private support, private support representing the minority interest of the public. The public, however, usually allows its agents to give leadership and within limits to express their personal interests. In some instances it is possible to initiate a service on a proprietary basis in which that portion of the public which is ready to pay for service is given what they need and the remainder go unserved. This proprietary service may then whet the appetites of the "have-nots," whose demands must then be met in part on a private nonprofit basis or as a government function. Some services supported by Community Chests have arisen from proprietary beginnings.

The Survey. The survey is an informed examination of a community or a part of it analogous to the clinical examination of a patient. It is a way of understanding a community and an agency. It is diagnostic, but at the same time is preparatory for, or perhaps the beginning of, steps toward improvement. However, in some instances the processes of a survey are used for other purposes, perhaps as a cooling-off or delaying action to tide over a community emergency, like the doctor who silences a patient with a thermometer while he decides what to do next. Sometimes a survey is a way of getting an outside and supposedly unbiased authority to say things that a local authority could not say with equal force, or only with jeopardy to its local leadership. Figuratively the survey conducted by an outsider baits and traps local hostility and either resolves it or runs off with it.

An excellent outline for a community mental health survey [1] has been published by the Group for the Advancement of Psychiatry. This, however, leads to a description of the status rather than the dynamics which created the present state of the community.

Authority. Authority can be an effective instrument in social action for mental health. In fact, its use is inevitable. Whether it is effective or not depends on where, when, and how it is used and whence it is derived. Authority may be based upon law, status, a bold front, or a broad knowledge and experience in the field. But in any case it must be used with circumspection if it is to be enduringly effective without creating dependence. A distinction should be made between authority that is authoritarian and that which is authoritative.[2] The latter emerges from the qualities of the individual quite apart from his formal investment and is perhaps better identified as leadership. It may stem from his personality qualities or from a command of special knowledge and techniques. But since several persons may be more or less in command of special knowledge and techniques, the sharing of authority is conducive to strength. However, care is needed that the sharing of authority does not confuse responsibility. Some people find it hard to share authority and creative satisfaction and glory with others. This is in itself a problem of mental ill-health.

Sometimes it is necessary to inspect reputed authority to see how genuine it is. Mr. Smith, for example, because of his personal and executive qualities is appointed to an administrative position in a field with which he is not technically familiar. The newspapers report this. Immediately Mr. Smith is treated as a technical authority beyond his competence. He is called upon for advice and decisions that go beyond his experience. As a wise administrator he responds to these demands by proxy rather than directly. He uses those who have knowledge and experience to meet the demand. A glaring example of authority derived from an irrelevant status was the newspaper advertisement on the day after a heavyweight boxer was crowned in which he advised the public to use a certain patented tonic. It was said that his losing opponent also held a contract to give this advice should he win.

The effectiveness of the use of authority depends upon the general cultural and political context to which it is employed. If authority is the order of the day, as in an authoritarian regime, its effectiveness will last as long as the whole regime. Paradoxical as it may seem, the use of authority in that case may hold the only prospect of social change. But if the regime depends upon public participation and support, authority to be effective must enlist public understanding. Such authority dares not to get too far ahead of the public. This means that it may have to slow up a forward movement in order to bring the public along with it. It must welcome, invite, and endure criticism, and it must therefore be more rational in its acts and its force more dependent upon knowledge and experience than status. For there are always those among the public who are knowledgable and experienced enough to challenge the use of authority, or to give good support if that is in order. The use of imposed authority may move a service ahead rapidly. But the service is likely to reach a peak and then slip back to the earlier level. With a well-measured use of authority the gain is slow and continuous or intermittent.

The wise use of authority is described in a discussion of the exposé by Deutsch.[3] An exposé should, of course, be the result of a survey. Otherwise it is sheer demagoguery. It should depend on a careful scientific analysis of a situation in which the role of the public and its failures have been made evident. A good exposé is set in a larger plan of strategy in which representatives of the general public are involved and are ready to stabilize and continue any advances that are made. On the other hand, an exposé may be used as a form of blackmail—a threat to force action without too much concern about accuracy. Such gains as are made in this way are seldom lasting.

Since the authoritarian tends to get out in front of others, he does not tend to pass responsibility on to them, and the situation is not conducive to citizen growth. Solid progress in the mental health field depends upon using to the fullest the capacity of the citizen and upon building his capacity up rather than relieving him of any responsibility that he can carry. Sometimes, where he is not prepared to carry responsibility and where failure would inevitably result from depending heavily on him, his share in a program needs to be small. But this reduced responsibility should be coupled with steps to enhance his capacity so that authority may be minimized and turned as far as possible into leadership. In Chapter 1 it was pointed out that mental health, while inherent in the person, reveals itself in the way he deals with other persons. Undue use of authority is apt to be a sign of weakness of faith in one's own powers of persuasion.

Personal Involvement. In Chapter 1 reference was made to the fact that many persons active in the promotion of mental health are attracted because of personal experience with mental illness. Some of these are former patients. Most mentally ill persons are characteristically unsure of themselves. Even after recovery from their illness this immaturity may continue. Those who are partially recovered are especially insecure. Former patients have shown that they can make a great contribution to the advancement of mental health. They know the problem, and they have feeling enough about it to motivate them to action. If they are uncertain about themselves, they are apt to be overly authoritarian and aggressive. This is where good, steady, sound leadership is crucial.

SOCIAL ACTION

It was pointed out in Chapter 4 that the deficiencies of our psychiatric service stem from several causal factors. Among these is defective (immature) citizenship. In fact, that is the most common factor and the one which has the most serious consequences. It is, therefore, essential that every effort to improve services strive to strengthen citizen responsibility. The maturation of a citizen is not achieved by exhortations or abstract instructions. It is an outgrowth of experience, and so a program which *helps him to do* instead of *doing for him* is more conducive to the solution of this factor.

Those who are exercising citizen leadership in the advancement of mental health do well to be mindful of several principles:

1. Those who devote themselves either as volunteers or as employees of voluntary agencies of mental health may justly claim no higher quality of good faith, altruism, or intelligence than paid public servants or professional workers.
2. Respect for the other person is one of the earmarks of mental health.
3. The personnel in professional and public agencies have in general a fuller appreciation of the problems and deficiencies in their work than have the volunteers.
4. In general those who conduct professional and public services have hopes for improving their services that are blocked by financial and other obstacles of which they are more fully aware than are others. These are discussed in Chapter 4.
5. A survey of the community can unwisely ignore these professional and public persons, and the surveyors can try to inform themselves independently. But a program conducted in that way is slower, less complete, and more costly than when these persons are considered partners. It excites more distrust and antagonism and lays the foundation for opposition to the execution of the program.
6. Should a professional person or public servant be undeserving of respect and trust, there is no surer way of discovering that fact than to accord respect and trust and then to find them violated.

There are two other guiding principles in program execution that bear upon the relation between the professions involved in mental health. The first is that the advancement of a profession and its work is dependent largely upon its own leadership. The second is that leadership can usually be found within the ranks that is fully as interested as outside leadership and better informed. The strategy of program execution calls for identifying such internal leadership and unobtrusively backing it. Harm may be done when one profession tries to assume the leadership of another. This has been emphasized in the chapter on the school.

MENTAL HEALTH ASSOCIATIONS

The one agency whose primary role is pathfinding and the promotion of social advances in behalf of mental health is the mental health association. In Chapter 1 the philosophy of a citizens' mental health association was described. This has been developed in greater detail by the author elsewhere.[4] An example of how a mental health association studies its community and moves into action is to be found in another article.[5]

As of March, 1955, there were 44 state mental health associations in the United States, of which 29 were affiliated into a national association. There were some 240 local (usually county) associations affiliated with the state associations. The membership of the World Federation for Mental Health included 34 national mental health associations. Several of these are organized very much as is the National Association for Mental Health in the United States. Some are federations of other national organizations, both professional and citizen. Some receive support from public funds. Governmental support of a mental health association is considered in the United States to be an encumbrance on the freedom of action of a citizens' organization. But it must be kept in mind that in other countries citizen responsibility and authority and governmental agencies are often differently conceived.

In view of the concept underlying a mental health association, the fullest possible opportunity should be given interested and capable citizens to participate in the execution of its program. Such use greatly expands not only the potential for action but also the citizen's understanding of the need in the area served and of his role as a citizen. It also gives confidence to the community that it has leadership within its ranks. It is a great asset in any community to have a group of citizens that has studied some aspect of mental health locally and that has informed itself of progress in other places.

The effective employment of the citizen in social action calls for a staff that is interested in making the fullest use of him, even if on occasion a task can be done more promptly otherwise. Professional participation and guidance are indispensable, but it is well to keep in mind that there are certain aspects of social action to which a nonprofessional member may apply himself with as much authority as the professional. For example, a group of citizens which has devoted itself to the improvement of legislation learns how to proceed in such matters. There is no formal training for it. The citizen is the full authority in determining for what problems he should have help, but he must depend upon professional knowledge and judgment in planning services.

AIMS AND INSTRUMENTALITIES

One of the pitfalls in social action for mental health is the failure to distinguish between an aim and an instrumentality for executing a program. For example, if the program includes the promotion of psychiatric services in a general hospital, then education, professional training, research and legislation are properly focused on that objective and projects using these techniques selected with that in view. In contrast with such specific use of instrumentalities one often finds a free-floating decision to carry on "a program" of public education, of research, or even of legislation without first deciding on the social action to be aimed at. Sometimes a goal really exists, but it has not been clearly spelled out and hence is an uncertain guide. Where several persons must coordinate their efforts, it is better to be explicit so that each understands what the other is working toward. These instrumentalities and how they may be used warrant specific attention.

EDUCATION

There is probably no subject that engages the public interest as greatly as does mental health. Why not? Everyone, minute by minute, in his feelings about himself, in his dealings with other people and in keeping with the realities of the world about him is happy, congenial, and successful, or the opposite depending in large part upon his own mental health. At the same time there is no subject that is likely to arouse so much anxiety and hesitation as mental illness. Again, why not? Everyone knows himself better than he knows other people. He knows his failures, he knows that he is sometimes unreasonable, and he knows that his mental processes are not always sound. Imperfection is a part of normal living. Since he does not know about other people as well as himself, he does not know about their imperfections and their qualms and anxieties. To him other people look sounder than they are. A comparison is always to his disadvantage. He hopes that his mental health is not too far off base—and usually it is not—but since he is not sure he would rather steer clear of the whole disturbing business, including those who are trying to give him information about mental health and mental illness. He shudders at the thought of a mental hospital, but in reality he is shuddering at his own imperfections. He would not be so concerned if he could accept the fact that "to err is human" and the right to make honest mistakes one of the earmarks of democracy.

This conflict of public interest and aversion is a major problem to those who are attempting to advance the public's understanding as a basis of social action in behalf of mental health. It cautions slow progress. The average citizen likes to feel his way along, taking small doses of education and not investing too much emotional risk all at once.

Several studies have been made to determine the attitude of the public toward matters of mental health and illness. The most pretentious study is that conducted by the National Opinion Research Center [6] under grants from the National Institute of Mental Health and the Commonwealth Fund and with advice of the National Association for Mental Health. This study revealed some confusion and uncertainty on the part of the public, but still a tendency to vest the term mental illness with the grimmest connotation, insanity. At the same time the public sees that there is a relation between mental illness and neurosis or "nervousness." There is also a tendency to confuse "mental" with "intellectual," which is only one aspect of the mentality. These and other attitudes can cause an educational effort to misfire rather badly. Anyone who is undertaking educational work in the mental health field should be acquainted with the revelations of this study.

Of course, education aimed at social action is conceived differently from education in schools and colleges. These institutions make education a goal in that they try to help a student to acquire a good understanding of the world but do not clearly define how this knowledge shall be used. They provide him with a foundation to deal in an informed way with problems as they come along. Where, however, social action is the more immediate aim, education calls for such questions as "What change or condition do you want to bring about?" and then secondly, "What knowledge is needed by those who are in a position to bring it about?" The answers to these questions serve as a guide to education. When the distinction between program and instrumentality is made, one does not encounter such free-floating proposals as "Let us have a program of education in mental health," or even more specifically "Let us have some kind of a film." When the goal is set specifically one can begin to choose the knowledge that will best advance the purpose.

The failure to define a clear-cut purpose is not simply the result of a desultory approach to mental health education. It often has more depth and meaning than that. Education without a clear-cut goal cannot be evaluated; its results cannot be challenged. Vagueness is therefore safe, and so it can be rather seductive. Long reports are often written about educational activities, but one often has to surmise the end toward which the activities were pointed.

Steps in Planning Education. If education is to be one instrumentality among several used to achieve a goal, certain steps may help to ensure its proper place in the total scheme:

1. The first step is to decide what result is aimed for. This is the *goal.*

2. The second step is to design the strategy that will lead to the goal. This is the *plan.*

3. The third step is to identify persons who will be involved in the plan and the roles that these persons will play in the movement toward the goal. This is the *audience* and its *role.* Every program calls for the participation of people—sometimes singly, sometimes in groups. From step to step they may be very different people: general citizens, teachers, clergymen, doctors, the parents of babies, or the parents of school children, or professional societies, or their leaders, or executive authorities, such as governors. The people who need to be moved, to think, feel, and act in favor of the program cannot be identified by any rule of thumb. Careful study, beginning with the survey, and planning will help identify them and the useful role that they can play. For each phase of the program they are different, and their participation must be differently timed. It is ineffective simply to pour a wealth of mental health education into these strategic people. Effective education must be tailor-made and it must help these people to understand what they can do. Also it is better if their backgrounds are understood, for the backgrounds may be so different that they require very different motivation. Some will respond only to forms of motivation, such as pressure, that are hardly dignifiable as education.

4. The fourth step is to determine what additional knowledge and understanding or change of attitude must be brought to these persons. This is the heart of the educational effort—the *message.*

5. The message cannot be transmitted indiscriminately through any media. Certain media are better adapted than others to a certain message and to certain persons. These media must be decided on. These are the *channels*. The channels of education are sometimes simple. People talk with each other in everyday informal ways. But for mass education there is an organized body of knowledge about addresses and lectures, films, stage plays, radio, television, news reports, and other media. There are also specialists who may be called upon to advise on the use of these channels so that valuable resources are not wasted in a misguided educational effort. The National Publicity Council for Health and Welfare Services [7] has long experience in the use of channels.

6. Finally, having carried the first five steps into execution, there is need to test the results to determine whether the plan, the audience, the message, and the channels were successful in accomplishing the goal. This is evaluation. Ridenour [8] has analyzed methods of evaluating education. She warns of the fact that sometimes the result proves to be quite the opposite of that which was intended. Telling a fact does not mean that it is either understood or accepted. She points out that results are hard to measure but that expert opinion is of some value as a guide. Also there are some "uncodified criteria" that may be called upon for guidance. Emotion, for example, is known to influence learning. But can it be controlled so as to contribute to the goal? Can its effect be judged in advance? Many "educational" efforts are essentially exhortations to the audience to assume a different attitude. But when one thinks how difficult it is to change an attitude of one person by using intensive individual clinical techniques, it is evident that only the rare evangelist is a successful exhorter. Instead the approach needs often to be very indirect and subtle. Exhortations such as "be calm," or "stop worrying," or "don't be so complacent" have value chiefly in reflecting the intended message and the naïveté of the person attempting to convey it.

PERSONNEL

In view of the wide range of personnel required for the services described in Chapters 4 to 22, it is obvious how important is a supply of skilled workers. The personnel of hospitals, schools, the church, the court, social service, and all other agencies dealing with people in need or in trouble are adequate to the extent that they have been prepared to understand human behavior and within the range of their duties to deal with it.

Many a service has been well planned and well financed only to be held up because staff cannot be found. Again and again staff has been secured only at the expense of some other on-going service, which then inherits the staff shortage. This chain of events is not an unmixed evil, for the competition has made it necessary to design services better so as to attract personnel. But the shortages could be less acute and still ensure that advantage. The shortage of personnel has been attacked by making jobs more attractive, by improving professional education, and by the provision of scholarships. Making the job attractive is the most effective measure, as shown by the relative ease in filling positions in well-located and well-equipped veterans' hospitals. Improvement in training and scholarships have great social value, but they prepare the trainee to forge his way into any position and so he is more apt to leave the institution which is hampered by staff shortages. Malamud[9] in a presentation before a conference arranged by the Council of State Governments has made specific proposals for meeting the shortage of personnel.

The influence of competition is evident in the field of psychiatric social work. There has been a tremendous loss of psychiatric social workers by psychiatric agencies, chiefly to social agencies dealing with families and children, because the competing opportunities in other fields have been so great and because the quality of their training has enabled them to give leadership and make a contribution outside their original field. They have enriched the curriculum of social work generally, for much of their basic training has been adopted for all social work. They have helped to make social work an attractive field to young men and women. Their understanding of the dynamics of human behavior has helped social work more than any other profession to deal with the psychological relationships between the trainee or staff member and the supervisor. The principles and techniques of supervision which have been developed in social work are slowly being adopted by other professions.

The American Psychiatric Association has sponsored two important working conferences on professional education, one for the psychiatric aspects of the general field and the other for psychiatry as a specialty. These conferences have been interpreted in books[10,11] which serve as landmarks in psychiatric education. The principles expressed in these reports are in fact largely applicable to all fields. These conferences were supported by grants made by the National Institute of Mental Health under authority of the National Mental Health Act. Similar conferences have been held or are projected for psychology and other fields. The National Institute of Mental Health has, in addition, made grants to training centers to strengthen their programs. These grants have enabled the training centers to improve their personnel and equipment and to provide stipends for trainees.

The failure to build a new generation of personnel to a higher level than their predecessors is often due to the failure to realize how trainees learn. The trainee's concept of his professional task is most influenced by the way the master under whom he is learning performs it. If the master, e.g., a professor of pediatrics, by his practice gives full recognition to the mental health aspects of his work and demonstrates his interest with deeds, he is apt to be emulated. If he brings in a psychiatrist or other specialist in the field of human behavior to teach and supervise the student, the student learns that this is not an essential part of his job and he learns chiefly that he should pass these duties on to experts in another field. If a school teacher is too quick to refer to other community agencies children whose problems are an inseparable part of the concern of the classroom and the other agency is ready to accept the task, the teacher is pauperized professionally. If that teacher has student-teachers under him in the classroom, the loss is multiplied. The field of education, through its provision for student teaching under a master of the profession, has recognized that much education is carried on nonverbally. This nonverbal teaching is subtle: the student gets the feel of how the expert works and incorporates this with his own feeling, but probably never could describe many of his skills or why he has adopted them.

Still, no matter how excellent a new advance in the training of personnel may be, its merits are not entirely sufficient to bring it into general use. Such is the weight of tradition and administrative inertia. Citizen pressure is often needed, and citizens may need to fortify their efforts by partnership with professional leaders to break into the static situation.

A milestone in the administration of the preparation of personnel is the study and report of the Council of State Governments.[12] This report refers especially to the personnel needed in state services. Since this report was issued steps have been taken to plan for the training of personnel on an interstate and regional basis. The Southern states have taken the lead in this through the Southern Regional Education Board. This

Board has created a Commission on Mental Health Training and Research whose purpose is to advance these two functions within its area. The Commission is in part supported by a grant from the National Institute of Mental Health. It is concerned not only with the personnel involved in psychiatric and mental health services as such, but also with the mental health training of teachers, clergymen, social workers, and lawyers. State committees composed of legislative, professional, and lay members help this Commission both in the conduct of surveys and in the promotion of progress.

RESEARCH

There is scarcely a case in which service is being rendered that does not elicit from the professional person who is rendering the service the wish "If we only knew more." The same wish is aroused in those who are attempting to remove mentally hazardous community conditions and in those who are trying to bring about a better understanding of mental health and illness. The application of the criteria proposed in Chapter 2 in the case of many problems or projects makes it clear that so often the only sound step that can be taken to provide better service in dealing with a specific problem is to discover more through research. Research then becomes a means to an end.

One might expect that the incentive to and leads for research would, therefore, come from those who are providing services. This is the case within limits, but it is not true enough of those agencies which deal with the major load of cases. They are often so occupied that they fail to tell about their research needs and the leads that appear in their case work. Their traditions and isolation tend to foster institutional stasis which gives way only as an outside factor, perhaps pressure, breaks the hard shell. The Veterans Administration hospitals have shown the value of outside affiliation and contacts in breaking this isolation. Citizen action may be needed to produce similar results in other mental health agencies and thus foster both training and research.

It is impossible even to estimate how much is spent for research aimed at influencing mental health. Expenditures for research having to do with the prevention and treatment of mental illness roughly approximate $6,000,000 a year. When it is realized that serious mental deviation is an expression of over 100 different diseases, this amount of money shrinks in importance, for one can seldom carry on research into mental deviation in general. There must be specific research for each disease. There is, of course, some research that costs very little. It represents a labor of love by a dedicated person. But since such research is a side line, it can seldom progress very far.

The promotion of research is complicated by the great breadth of the mental health field and the great diversity of the sciences that are involved. It is further complicated by the fact that a problem which arises in one technical area, e.g., psychiatry, is likely to find its solution in another technical field for which the original profession has no competence. Research in one psychiatric disorder, schizophrenia, includes psychological, sociological, anthropological, psychiatric, genetic, biochemical, neurophysiological, metabolic, and other projects. It involves animal as well as human research and mathematical competence.

Those who are engaged in disciplines that use more precise scientific knowledge and methods often find it difficult to work with and respect and give support to the scientific work of those whose science is less exact. Some laboratory scientists refuse to concede that the social sciences are scientific at all. Ironically, many of the failures of society to use to the limit the contributions of the laboratory can be understood only through the processes of the social sciences. The identification and measurement of these road blocks is a task of social research and is an appropriate undertaking for those interested in advancing mental health. Studies of the attitudes of the public, the failure of a hospital to concern itself with the vocational plans of its recovered patients, the failure of the schools to take mental retardation more seriously, the success and failure of efforts to prevent delinquency—these are all appropriate and respectable research problems largely in the area of social sciences.

Coordination and Support of Research. The diversity of mental health problems and the factors behind them mean that teamwork between these different skills is often necessary both within a project and between different projects. Research conferences help ensure this team work. In this way those who are conducting research on a problem are brought together for mutual exchange. Some of the foundations, such as the Josiah Macy, Jr., Foundation, the Commonwealth Fund, and the Rockefeller Brothers Fund have made grants for this purpose. The conferences of the Association for the Aid to Crippled Children have furthered such exchange and facilitated progress in understanding congenital malformations, including those involved in mental deficiency. The Supreme Council, Thirty-third Degree, Scottish Rite, Northern Masonic Jurisdiction, United States of America, holds a two-day biennial conference, carried out under sponsorship of the National Association for Mental Health, of the principal investigators in its schizophrenia research. The National Institute of Mental Health has also done much to foster this cross-fertilization.

The Council of State Governments has a stated interest in helping in the exchange of information between research investigators. The Southern Regional Education Conference, referred to earlier in this chapter, is doing much to foster research in its area and especially in planning for the division of labor between the research centers so that their resources may be used with maximum effectiveness. The report on training and research of the Council of State Governments specifically encourages the states to provide directors of research and of training in order to coordinate and stimulate research under state auspices. The realization of this hope will be slow, however, unless citizens make it clear that they demand such leadership.

The Bio-Sciences Information Exchange is another device for the coordination of research. It maintains information on researches in progress in the United States and to a degree elsewhere. It is a creature of several Federal agencies which support it, but it extends its coverage and help to nongovernmental interests.

The National Research Council, a nongovernmental agency depending on private support for many of its projects, has several committees that are concerned with mental health. Its Committee on Alcohol makes grants for research, and it occasionally brings the principal investigators together for mutual exchange. Its research funds, about $42,000 per year, come in large part from the alcohol-beverage industry. Some of the states have set aside special research funds for studies in alcohol, but they have not found it easy to get good personnel and good research projects.

The National Association for Mental Health plans to allocate for research a portion of the funds raised in its annual campaigns. In this way it constitutes a pool for those who can make a small financial contribution to research. Contributions which would otherwise be impossible to administer can thus be used efficiently. The major single source of support for mental health research is the National Institute of Mental Health. Through its own research at the research center in Bethesda, its grants for research, and its help in developing research personnel, it has done much to advance the search for new scientific knowledge. Every year lay and professional citizens have appeared before congressional committees to testify to the importance of adequate support for this program. In addition they have asked for Federal grants for the construction and equipment of research facilities, a provision which still does not exist. Several of the most privileged states maintain sizable research programs and research centers.

Research in the mental health field is apt to be long-time research. A project may involve a life span. Some of the public support for research, however, cannot be assured for more than a year since appropriations are made annually, but sometimes assurance of intent is sufficient as a safeguard for long-term planning. The National Institute of Mental Health has in fact been able to approve commitments of up to four years' additional support.

Obstacles. One of the serious obstacles to research, as it is also to clinical work, is the shortage of personnel. This shortage is hard to overcome, for it involves so many disciplines. Sometimes a well-planned and well-financed research must be abandoned because technical personnel cannot be found. Even more serious, as for example in the case of mental deficiency, is the failure to design research projects because of the absence of a spirit of inquiry on the part of the personnel in the field. The shortage of personnel is difficult to overcome also because it increases as science progresses. The unknown is unlimited, and each discovery multiplies the leads for research and the demand for personnel. This phenomenon is well discussed by Malamud[13] in a presentation to the Governors' Conference.

If the training of a profession consists of indoctrination by a certain "school" while other approaches or "schools" are neglected, there is little incentive to inquiry and experimentation. In order to stimulate research the training of a profession for practice should provide an understanding of all the pertinent facts, theories, hypotheses, and techniques that bear upon the practice and an understanding of the scientific status of each. Then the uncertainties and gaps of science are brought into clearer relief and inquisitiveness is fostered. The trainee is then ready to acquire research skills, for he has imagination and also the incentive to find answers to the wish, "If we only knew more."

It might be supposed that research would meet with hearty universal support, moral if not financial. But the attitude toward science and the scientist is mixed, and to that extent it is in itself a deviation from mental health. Many people feel quite uneasy about the fact that scientific knowledge confers upon the expert a degree of control over nature. There is often hidden or overt glee when a scientist seems to have blundered. In the extreme this may be expressed in such cults as the antivivisectionists. Even professional people whose practice is supposedly founded on science but who themselves are scientifically uncritical will at times succumb to a cult of pseudo science.

Handling Scientific Claims. Those who are concerned with the advancement of mental health are confronted with many proposals involving "scientific" ideas, formulations, and conclusions on which they are expected to be able to form an expert opinion. Some of these ideas are so wild as to be rather easily evaluated as worthless. Others are quite intriguing and also reasonable. In between it is not so easy to avoid the error of rejecting a proposal because of one's own prejudices or on the other hand of being too liberal. Some scientists, remembering the experience of Pasteur and other innovators and the opposition they encountered, lean over backward in avoiding criticism of ideas to which they themselves give no credit. Some criteria may therefore be helpful in choosing between the wheat and the chaff. These criteria may help in deciding whether a technique is worth trying out or whether the use of our limited research resources for a proposed research is justified, especially if either calls for experimentation on human subjects. In the long struggle to find new cures to combat disease, it has been found that adherence to principles of scientific investigation is the surest and quickest path to progress and that any other path is costly. Medical progress has been fogged with well-publicized but unsubstantiated miracle cures which are short-lived. Many of these would fall before a set of good criteria. These "cures" force us to be critical, for their claims are often so broad that it would take millions of dollars and years of our best scientific effort to give them a full test.

When a new method of treatment is reported, the need for full substantiation of its claim is obvious. The first steps in that substantiation are the responsibility of the one who introduces the proposal. Unless he is willing to take these four steps he is not entitled to serious consideration of his claim: (1) the claimant should evidence such knowledge and experience as to warrant serious attention to his claim; (2) he should offer his protocols of experimentation (raw data) for scrutiny by scientists and should render them every assistance in their evaluation of his claim; (3) the principles, premises, reasoning, data, and conclusions set forth in the claim must be reconcilable with known facts and with the claimant's own data; (4) his findings should be presented before an unbiased forum of those who know the field and who are warranted in judging or challenging the soundness of his experimental methods, his data, and his derived conclusions. This does not imply that he should be subject to the formal approval or disapproval of this forum, but after he has received their opinion his moral as well as scientific obligations are sharpened.

After his findings have been presented to the experts in the field and have been subjected to their questions, criticisms, and further experimentation, it may be evident that they warrant trial. Unless these conditions are fulfilled, scientists are hardly justified in devoting precious effort to the testing of a proposal that bears upon mental health, to say nothing of being obligated to do so. This is especially the case where such testing must be done upon human subjects, and particularly upon persons unable to assume full responsibility for their decisions. The layman may well inquire as to whether a proposed innovation has fulfilled these obligations and may thereby do much to foster scientific progress in mental health.

CITIZEN MOBILIZATION AND POLITICAL ACTION

Earlier in this chapter citizen mobilization was discussed as one of the instrumentalities of social action. One of the objectives of citizen mobilization that warrants special place in program execution is legislation. So many of the agencies that are concerned with mental health come under public auspices that political action is a responsibility of every citizen. The term *political action* covers much more than participation in the decision of legislative bodies: Congress, state legislatures, city councils and county committees, boards of education, etc. It has to do with judicial and executive functions as well. The regulations of an executive agency often determine whether in its execution a law proves good or bad for mental health. Regulations determine whether appropriations which the law authorizes are controlled strictly in every detail or permissively with considerable latitude. Sometimes budgetary items can be transferred and provide an opportunity to meet needs of high priority that were not evident when the budget was passed. Regulations influence the appointment of personnel. Executive decisions have important bearing on the use of general authorizations, such as bond issues.

Just as the other instrumentalities of program, such as public education, have their special body of knowledge and technique, so also does political action. The difference is that this knowledge is less organized, tested experimentally, and translated into a curriculum than education and research. It is, nevertheless, important to "know the ropes." Valuable guides and suggestions can sometimes be obtained by citizen groups from former public officers. Any statesman who is interested in mental health could give counsel on wise steps in political action. An organization interested in the advancement of mental health does well to develop a committee of citizens who can come to "know the ropes" and be available when a need arises. Such a committee can help in the planning of a program so that it is more realistic and can serve to steer a citizen toward his goal when he must go through political channels. Such a committee takes its place alongside of committees concerned with public education, professional education, research, publicity or public relations, and finance.

One of the worries of such a committee is its consciousness of Federal income-tax restrictions. It is provided by law that those who contribute to benevolent organizations may up to a certain limit exclude these contributions from their taxable income for Federal income-tax purposes. But it is also provided that no substantial part of the work of such organizations shall be directed toward influencing legislation. Whether "substantial" refers to an absolute amount or a percentage of all expenditures, no one in authority is willing to state. Whether this refers only to lobbying, i.e., putting pressure directly on a legislator, or other forms of influence is also unclear. Where does education in support of social change that may entail legislation cease to enjoy freedom from this restriction? This is not clear. It is generally understood that testimony before a legislative body or its committees is not encumbered by this restriction. Some organizations meet the problem in part by charging everything possible to education and as little as possible to legislative action.

It is not generally understood that a department of the executive branch of a government cannot set its policies independently of the policies of its chief executive. Its policies must be harmonized with those of the chief; otherwise, chaos ensues. For this reason the staff of such a department must subordinate their personal views in so far as they are enmeshed with their official duties. A state education department head may feel that appropriations for mental health in the schools are inadequate, but he can only thrash that out with his chief. He cannot carry it to the public or incite them to action.

There is much, therefore, for a body of citizens expert in political action to come to know as to what is wise and what is lawful so that they may properly advise on and direct political action for mental health.

In Chapter 2 the importance of teamwork among professional, governmental, and volunteer organizations in program planning was discussed. This same type of teamwork extends over into program execution.

It is pertinent in conclusion to offer a quotation from the Chinese philosopher Ku Te Ling, for which the author is indebted to Dr. James A. Stringham: "Whether a country flourishes or flounders, the responsibility is shared by the average citizen."

NOTES

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24 WORLD MENTAL HEALTH

It may seem inappropriate to devote a special chapter to world mental health activities, since there has been no comparable discussion of national (except for the United States), state, or local mental health activities. However, there are definite reasons for making this exception. First, the concepts presented or implied up to this point are applicable to only a part of the world. Some are especially pertinent to the United States. Unless, therefore, one takes the position that the philosophies and the cultures of one country should be generalized, he must be ready to see the promotion of mental health and in fact mental health itself as more variable than is found in any one part of the world.

Much that has been presented in previous chapters is postulated upon a concept of citizen responsibility that is expressed in such documents as the Declaration of Independence, the Constitution of the United States, and the address by President Lincoln at Gettysburg. Relatively few citizens have actually matured to that extent politically. It has been pointed out again and again that immaturity of citizenship is one of the great obstacles to progress in mental health in the United States. When the citizen fails to meet his responsibilities in a democracy, there is no authority to fill the gap. The greater his responsibility, the more serious is his failure. In some parts of the world the mature functioning of the citizen entails less responsibility. In such cases citizen maturity is more easily achieved for it is less demanding. In some places the government, while not authoritarian and while entirely at the command of the people periodically, is not so responsive to citizen pressure in the interim. In other countries the citizen is less a political authority than a subject at all times, while in totalitarian nations he is an agent of government—the reverse of democracy. It is, therefore, in some countries hard to find a parallel of citizen action for mental health. These differences become evident whenever an international congress on mental health is held. Some countries are represented only by governmental delegates.

INTERDEPENDENCE OF COUNTRIES

At the same time the interdependence of the countries of the world is an inescapable fact. The scientific progress that is concerned with the restoration, protection, and elevation of mental health comes from all parts of the world and attests to the fact that no country is sufficient to itself. For example, if one were to visit a mental hospital in the United States, he would see many diagnostic and therapeutic procedures in use. If he were to inquire into the origin of each of these, he would see how extensively the United States depends on scientific progress made elsewhere in the world. He would find such diagnostic procedures as the Binet test from France and the Rohrschach test from Switzerland. He would find fever therapy for general paresis from Austria, as well as insulin shock and psychoanalysis from the same country. The drug insulin was a Canadian contribution. Metrazol convulsive treatment from Hungary might be no longer in use, being succeeded by electroconvulsive therapy, which originated in Italy. He would find lobotomy in use, originally developed in Portugal. Alcoholic cases might be under treatment with Antabuse, a product of Denmark. If he moved over into the field of mental deficiency he would find progress in England which has not even as yet been adopted in the United States. He would also find a broader regional, rather than institutional, concept of public psychiatry there. He would find that a most significant and recent contribution to an understanding of the cause of one form of mental deficiency came from Australia, i.e., the discovery that German measles in the pregnant mother may produce defects in the child.

In recognition of the interdependence of countries in the scientific field, graduate schools, especially those of medicine, demand of their students an ability to read the scientific literature of those countries which are most active scientifically.

Of late years there has been a great increase in the exchange of teachers and students, the provision of scholarships, and the use of imported consultants. This exchange attests further to the interdependence of the nations. A stream of foreign visitors is continuously attempting to pick up new advances and import new developments. Brief reference was made in Chapter 2 to the world organization as a fourth partner along with the local, state, and national agencies in the promotion of mental health. It was also shown that these world agencies are conceived as citizen, professional, and governmental agencies, although, as has just been pointed out, such a classification does not hold for all countries. A brief perspective of these agencies follows.

INTERNATIONAL MENTAL HEALTH ACTIVITIES

By 1930 the development of a community of interest of the countries of the world in mental health had progressed so far that some formalization of interchange seemed needed. The National Association for Mental Health, under the stimulus of Clifford W. Beers, thereupon took the initiative in planning and conducting the First International Congress on Mental Health in Washington. This Congress resulted in the formation of an International Committee for Mental Hygiene to be concerned with the common mental health interests and consolidate the leadership of many countries. However, this Committee depended far too much upon the leadership of the United States. As is the case with so many international organizations, its functions were mainly concerned with the conduct of congresses until 1948.

World Federation for Mental Health. The lack of interchange throughout the world during World War II brought about a demand for more continuous interchange and for equal participation by the member countries. This demand was met in 1948 by the organization of the World Federation for Mental Health during the Third International Congress for Mental Health in London to succeed the older Committee. This Federation comprised a membership of mental health and related associations from many (48 in 1954) countries. The World Federation for Mental Health carries on its functions through a staff working under the authority of a multiprofessional and lay executive board, and with the advice of a multiprofessional international scientific commission.

The Federation continues to hold congresses and smaller meetings, but congresses and meetings are no longer its main function. The meetings and congresses are not to be minimized. They have special value for the host countries in which they are held and in nearby countries, for they bring in lecturers and consultants for local use. In addition, they serve as an informal meeting ground for persons from many countries, so that one may call upon the experiences of another often to supplement previous correspondence. At the annual meeting those who attend are assigned to small international discussion groups to deliberate on the world aspects of various mental health matters. Most of the participants in the working groups are inexperienced in international communication and deliberation. But through their participation in these groups and less formal association with other delegates they come to view mental health from a world, or at least a widened, perspective. This broadening occurs even more in the members of the Executive Board, who as a result have come to think and plan together on international problems without special pleading for their own countries and disciplines. Leaders of such breadth are in the interim a great asset in their own countries.

The continuing work of the World Federation for Mental Health is carried out largely through the staff with the occasional enlistment of help from others, especially from members of the board. For example, through the volunteer help of one board member it aided in the establishment of a mental health association in the Philippines.

The Federation has been accorded a consultative relation with several of the official world agencies: World Health Organization; United Nations Educational, Scientific and Cultural Organization; United Nations Economic and Social Council, and the United Nations International Children's Emergency Fund, all of which carry on mental health activities. Some of the ongoing activities of the Federation are carried out in collaboration with or at the request of these agencies. Its consultative status gives the Federation the advantages of an adviser and observer to these agencies and has been effective in furthering their mental health work. At the suggestion of the World Federation for Mental Health, UNESCO conducted an intergovernmental conference on mental health in schools. The Federation collaborated with UNESCO in developing the Council for International Organization of Medical Sciences (CIOMS), an agency to facilitate congresses of international nongovernmental health organizations. With the support of WHO, UNESCO, U.S. Public Health Service, and others, the Federation conducted a residential seminar on mental health at Chichester, England, for over 50 public health leaders from 30 countries.

In view of the rise in the provision of technical assistance by the experts from one country to another and the potential influence of the resultant technical change on the mental health of people, the Federation worked with UNESCO in the preparation of the latter's book *Cultural Patterns and Technical Change.*[1] This book is designed to guide persons who are giving technical counsel to a people with a different culture to work as fully as possible within the patterns of the indigenous culture. As expressed by Rees,[2]

> The selection of delegates who represent their countries in the international field is perhaps a thorny problem, but an extraordinarily important one. People who are totally unsuitable may be selected on inadequate grounds for such tasks. They may be sensitive and touchy, self-important or exhibitionists who must talk to the gallery; they may have personality problems of their own which will lead them to create serious disturbances in the human relations of any international group, and there have been many sad occurrences of this kind. Surely, many of us could, with tact and patience, talk about matters such as this in our own countries, and we could at least make the responsible heads of government aware that there is a need to choose wise, well-balanced people to represent them and their point-of-view.
>
> We could go further than this, however, for we should be able to institute a process of mutual learning as between professional and technical people in our Mental Health Societies and those who are responsible for policy-making, and for presentation of that policy at the United Nations. It is well worth considering whether, in every country, there might not be small selected groups of people with real interest and technical knowledge in these fields, from our societies, who could invite the proper and responsible people from their government to come and discuss with them the forthcoming meetings of any of the United Nations bodies. Information can be provided as to when meetings of these various bodies are held, and it is not too difficult to find out in your own countries who the delegates will be, and some responsible person who would come and help your group understand some of the problems involved and the decisions which have to be taken. In the process of instructing a group, and discussing, he himself would also be learning.

At its first meeting the World Federation adopted some recommendations for the advancement of mental health. Those which pertained especially to the World Health Organization were accepted by that agency in principle, looking toward future inclusion in an active program. The Federation serves as a clearinghouse for world-wide information on mental health. It publishes a periodical, *World Mental Health.* Under contract with the WHO it has collected information from many countries about child adoption, student mental health, and psychotherapy in prisons. A major part of the work of the Federation has been focused upon the protection of mental health and the forces that make for good human relations. With the sponsorship of the Josiah Macy, Jr., Foundation it has conducted four conferences on "Problems of Health and Human Relations in Germany." These have resulted in the consolidation of mental health leadership and effort in that country.

The United Nations Economic and Social Council. This United Nations agency is charged with the coordination of world efforts aimed at the solution of economic, cultural, educational, social, health, and related problems. As such it is concerned on a world level with that teamwork of allied agencies that was discussed in Chapter 2 in connection with local planning. It is in a way a recognition by the United Nations that the integrity of the recipient of help should be recognized by the integration of services that are rendered to him. The Economic and Social Council, therefore, is not so much an operating agency as a team leader. It has recommendatory rather than executive functions. It stimulates joint or even singlehanded action by these other agencies. Of special interest to mental health is its work on behalf of social welfare, relief of children, delinquency, and narcotic addiction. It has given leadership in providing technical assistance and aid to undeveloped countries, including many which have mental health programs.

World Health Organization. WHO maintains a special staff to aid in the execution of its mental health function. Some of its activities are obviously concerned with mental health, e.g., the Chichester seminar previously referred to. Perhaps less obvious, but more significant, is its concern with the mental health elements in its other services, such as efforts for the control of communicable and insect-borne diseases. The failure of such efforts is often due more to adverse local attitudes that block cooperation than to lack of knowledge. Projects must, therefore, be designed to take this mental health element into account. An observer from the World Federation for Mental Health helped WHO to secure a cultural anthropologist to aid in the program of the African region, in order to circumvent obstacles raised by cultural influences among primitive peoples.

Many of the projects of WHO arise in and are carried out through its regional divisions with very limited central control. This affords an opportunity for citizens' and national mental health and professional associations to promote a more adequate mental health program within WHO. In most countries the channel to WHO is the national health authority. The Pan American Sanitary Bureau with headquarters in Washington serves as the regional division for the Americas. This Bureau helped the World Federation for Mental Health in planning for the Mental Health Congress in Mexico City in 1951.

In some countries there are citizen organizations specifically set up to improve and give backing to UNESCO and WHO. In the United States these are the United States National Committee for UNESCO and the National Citizens' Committee for the World Health Organization. The former is a governmental body authorized by Congress and operated by the State Department. The latter is purely voluntary. It was initiated by the National Health Council, whose membership is made up of professional and voluntary health associations. It maintains a close working relation with the United States Committee for the United Nations. Evidence of the effectiveness of citizen interest in influencing the mental health activities of WHO appeared when, as a result of a display of citizen interest prior to one of the world health assemblies of WHO, a psychiatrist was attached to eight national delegations.

United Nations Educational, Scientific and Cultural Organization. UNESCO is the agency of the United Nations which is concerned with cultural interchange. Its work therefore has important mental health implications. It has worked closely with the World Federation for Mental Health in carrying out specific mental health tasks. UNESCO especially needs informed citizen support because the influence on mental health of many of its activities is difficult to measure, as is the case with any general educational endeavor. Also its effort to facilitate international cultural exchange is disturbing to some insecure and anxious persons who can only see international exchange as subversive to national interests. UNESCO has conducted studies of high caliber pointed toward the better understanding of social tensions and ways of modifying them. It has also developed concepts and conducted experiments in fundamental education that take the indigenous cultures into account.

United Nations International Children's Fund. UNICEF was originally established as an emergency program to give help to children, especially those who have suffered severe social disruption. Since world instability now appears to be a more protracted phenomenon than had been originally anticipated, this agency has been made permanent. In view of the difficult plight of many of its beneficiaries, it has concerned itself with their mental health and has worked closely in this regard with the World

Federation for Mental Health, but its work in this respect is but a small beginning.

The Food and Agricultural Organization. FAO is concerned with adequate food production to meet human needs. In carrying out its functions, it must, like other world organizations, contend with many local prejudices and obstructing attitudes. In the introduction of new foods and processes it may disturb well-established family customs. It must, therefore, employ processes that are especially familiar to the mental health field. In addition, it is concerned with problems of rural welfare, many of which are inherent in the family and are essentially problems of mental health.

Other. A number of other United Nations agencies also touch upon mental health but perhaps more tangentially than those referred to above. The International Labor Organization is one of these. It is concerned with the health aspects of work and consequently with the matters discussed in Chapter 21. It is also concerned with labor standards, including those that bear upon children.

Several of the professions which are active in the promotion of mental health have established international associations. They vary considerably in strength, some being concerned exclusively with the conduct of congresses. Some are also active in the advancement of their field through international exchange, representation in international agencies, and advice to UN agencies.

SIGNIFICANCE OF CULTURAL DIFFERENCE

Advances in mental health depend upon the advancement of the sciences of human behavior. Scientific progress may be furthered by the discovery of differences in the mental health or illness of people that are related to the differences in conditions under which they live. In any one culture or country these differences may be small and their effects on mental health elusive. But the world as a whole includes variations that are tremendous and so also may be differences in mental health and illness. Anything that facilitates the exchange of knowledge about people and the way they live and behave may further the understanding of mental health in any one country. It is important to know of variations in the incidence of mental disorders in different countries and different cultures, for these differences may give the lead to an understanding of causes. But today few countries have reliable statistics about mental illness. The development of world-wide statistical reporting is therefore most important. It will probably devolve upon the world agencies—governmental and nongovernmental to bring this about. What goes on in any part of the world is of interest to the most remote inhabitant.

NOTES

1. Mead, Margaret: *Cultural Patterns and Technical Change,* International Documents Service, Columbia University Press, New York, 1953.
2. Rees, J. R.: "The Relationship of Mental Health Societies to International Governmental Agencies," *Bulletin of the World Federation for Mental Health,* 4:195–200, December, 1954.

VISUAL AIDS

The following motion pictures are recommended for use in illustrating the various concepts treated in this book and also as a guide to the planning of programs on the subject of mental health. While the bibliography is reasonably inclusive, no attempt has been made to list all films bearing on the subject. Readers, if interested in locating additional films, should consult the following references:

"Educational Film Guide." H. W. Wilson Co., New York 52

"Mental Health Motion Pictures." National Institute of Mental Health, U.S. Public Health Service, Washington 25

"Selected Films for Mental Health Education." National Association for Mental Health, New York 16

"Motion Pictures on Child Life." Children's Bureau, U.S. Department of Health, Education and Welfare, Washington 25

"Psychological Cinema Register." Pennsylvania State University, State College, Pa.

"Films in Psychiatry, Psychology, and Mental Health." Health Education Council, New York

"Directory of Professional Medical Motion Picture Films and Authors." Professional Publications, Lawrence, Kans.

All the motion pictures in the following bibliography are 16mm films. Unless otherwise indicated, they are sound and black-and-white films; those which are color and/or silent are so identified. Immediately following the title of each film is the name of the producer; and if different from the producer, the name of the distributor also. Abbreviations are used for the names of producers and distributors, and these abbreviations are defined in the list of sources at the end of the bibliography. Following the producer-distributor information is the year of production, an important factor in choosing films for public showings.

Each film is listed and described under the chapter heading to which it is most closely related. In some instances, films are listed by titles under other chapters with a reference to the primary chapter heading. Two groups of films which are helpful in the understanding of mental health and illness but which are not directly related to specific chapters have been added as appendices to the bibliography. Many of the films can be used for various purposes and audiences, and readers are urged to examine the entire bibliography in selecting films for specific programs.

Most of the films can be borrowed or rented from local sources such as public libraries, health departments, universities, or state mental health authorities. A list of these and other film sources is given in "A Directory of 2660 16mm Film Libraries," available for 50 cents from the Government Printing Office, Washington 25.

PART ONE—BASIC CONSIDERATIONS

Embryology of Human Behavior (AAMC/IFB, 1951, 28 min color). Explains that a child grows in accordance with certain universal laws and at the same time develops as an individual. Traces the patterning processes of behavior.

Judging Emotional Behavior (Churchill, 1953, 20 min). A motion-picture test designed to measure the sensitivity of individuals to the emotions of others. Ten sequences are shown in which two people react as if certain events described by a narrator were happening to them.

Mental Health: Keeping Mentally Fit (EBF, 1952, 12 min color or b&w). Defines and describes mental health and discusses its importance to the individual and to society. Illustrates symptoms of various mental disorders.

The Nation's Mental Health (MOT/McGraw, 1951, 18 min). Shows facilities for training psychiatric personnel in hospitals, various methods of therapy for psychiatric patients, and the work of the National Association for Mental Health.

Psychiatry in Action (BIS, 1943, 60 min). Presentation of the results and treatment of war neuroses in British hospitals by professional workers in the fields of medicine, psychology, psychiatric nursing, neuropsychiatry, social work, and occupational therapy.

Search for Happiness (MOT/McGraw, 1948, 17 min). Portrays man's attempts to cope with the complexities of modern living, and his susceptibility to cure-alls and nostrums.

Shades of Gray (USA, 1948, 66 min). Portrays through dramatized situations and case histories various mental disorders experienced by soldiers during training and combat, ranging from mild anxiety states to severe depressive reactions and paranoid psychoses; traces the life patterns of each affected soldier and relates his early familial and environmental experiences to the circumstances which precipitate his mental breakdown; demonstrates methods of psychotherapy, including emotional catharsis, narcoanalysis, hypnotic suggestions, and group therapy; and makes the point that in terms of mental health, no one is either "black" or "white"; everyone is a "shade of gray."

Unity of Personality (PCR, 1946, 18 min silent). Demonstrates similarities of expressive behavior characteristics of five individuals with very different personalities. The behavior patterns shown include gestures, facial movements, handwriting, handling objects, athletic activities, and walking gaits.

What's on Your Mind? (CNFB, 1947, 11 min). Discusses the strain of modern life upon the mental health of individuals, how millions try to find surcease in the advice of quacks, and why psychiatry offers genuine help for many mental ills.

Why Won't Tommy Eat? (CDHW/Sterling, 1948, 19 min color). Uncovers both physical and mental causes of the problem of the child who refuses to eat.

PART TWO—THE RESTORATION OF MENTAL HEALTH

Chapter 3. The Mentally Disordered

I Am an Alcoholic (RKO/McGraw, 1948, 18 min). Story of Alcoholics Anonymous and of its services to individuals and to society.

The Lonely Night (MHFB, 1954, 62 min). Story of a young woman's journey out of the dark hours of emotional disturbance. Shows the process of psychiatric treatment candidly and completely and the kind of family life that can help build emotional strength.

Mental Mechanisms (CNFB/McGraw, 1947–1955). Series of five films portraying, through dramatized case studies, certain mental health problems of young adults and tracing the roots of the problems back through adolescence to childhood and infancy.

1. *The Feeling of Rejection* (1947, 23 min). Documentary-dramatic

study of a young woman whose feelings of rejection are manifested in maladjustment and physical illnesses. Traces her feelings of rejection back to childhood origins, through flash backs, and shows her beginning, through psychiatric help, to understand her problem.

2. *The Feeling of Hostility* (1948, 27 min). Documentary-dramatic study of Clare, a young woman apparently successful in her profession but a failure in personal relationships. Traces her hostility, back to childhood experiences, through flash backs, and shows how psychiatric treatment helps her direct her hostility into constructive efforts.
3. *Overdependency* (1949, 32 min). Dramatized story of a young married man whose inability to face the ordinary problems of life, including vague physical ailments and vocational maladjustment, stems from a childhood too dependent upon his mother and sister.
4. *Feelings of Depression* (1950, 30 min). Dramatized case study of how and why feelings of depression shadow the business and home life of John, a conscientious young married man. Explains how psychiatry could help him understand himself and the reasons for his feelings.
5. *To Serve the Mind* (1955, 25 min). Case study of a doctor who suffers a schizophrenic breakdown, showing the various forms of treatment that gradually lead to his recovery and return to work.

✓ *Out of True* (BIS/IFB, 1951, 41 min). Story of a typical case of mental illness, followed through to its conclusion, which centers upon Molly Slade, who lives with her husband, two children, and mother-in-law in a crowded block of flats. Shows how Molly recovers through expert psychiatric treatment and returns to her family.

See also films described in Appendix B.

Chapter 4. State and Local Psychiatric Services

Breakdown (CNFB/McGraw, 1951, 40 min). Case study of a young woman who has a schizophrenic breakdown. Follows the course of her treatment from a mental health clinic to a state hospital and concludes with her discharge from this institution to complete her rehabilitation as a member of her family.

City of the Sick (ODMH/NAMH, 1950, 20 min). Life in a mental hospital through the story of an attendant who learns how mental patients can be restored to useful living.

Man to Man (MHFB/NAMH, 1954, 30 min). Story of how Joe Fuller, a psychiatric aide who takes a temporary job in a state hospital, decides to stay permanently in this kind of work. Shows the nature of the hospital work and the satisfaction of bringing mentally ill patients back to health.

Mental Hospital (Okla/IFB, 1953, 20 min). Day-to-day story of the treatment received by a mental patient from the time of his admission to the hospital until he is discharged.

Nurse's Day with the Mentally Ill (PCR, 1954, 22 min color or b&w). Shows typical activities of a student nurse in a modern psychiatric hospital. Includes many spontaneous examples of the behavior of the mentally ill. Showings restricted to professional audiences.

Someone Who Cares (Ind U, 1955, 22 min). Points out the too-frequent overcrowding and monotony in mental hospitals and gives examples of the contributions being made by citizen volunteers who bring to the mental patients program services such as games, music, and parties.

Working and Playing to Health (MHFB/IFB, 1954, 35 min). Shows the programs of recreational, occupational, and industrial therapy for the patients of a state mental hospital. Explains how and why these techniques are used.

Chapter 5. Veterans' Psychiatric Services

Activity for Schizophrenia (USVA, 1950, 25 min). Shows how physical therapists under the guidance of psychiatrists establish interpersonal relationships through intensified physical activities and motivate patients from lower levels of activity to more socialized levels.

Hydrotherapy Procedures for Neuropsychiatric Patients (USVA, 1949, 22 min). Describes hydrotherapy procedures for sedation and stimulation and emphasizes the importance of care in handling patients with mental illness and of good relationships between the patient and the physical therapist.

A Positive Approach to the Psychiatric Patient (USVA, 1955, 30 min). Shows the treatment in Veterans Administration hospitals for psychiatric patients who have emerged from acute episodes of mental illness but who are not yet well enough to leave the hospital.

Rehabilitation of Chronic Neurological Cases (USVA, 1947, 20 min). Explains the rehabilitation program at a Veterans Administration hospital by following a patient through the entire rehabilitation course and observing the development and characteristics of the program.

Road to Reason (USVA, 1951, 28 min). Explains phases of the treatment given mental patients in Veterans Administration hospitals.

Rx Attitude (USVA, 1952, 18 min). Stresses the importance of attitudes exhibited by hospital personnel toward mental patients and portrays the effects of such attitudes upon patients in a Veterans Administration mental hospital.

Chapter 10. The Legal Offender, the Police, and the Court

Children of the City (BIS, 1944, 30 min). Portrays the problem of juvenile delinquency and how it is handled in an urban area of Scotland and describes in detail how three boys, from three different types of homes, are dealt with.

Glass Houses (Brandon, 1954, 27 min). Portrays the problem of juvenile delinquency through a typical court situation involving representatives of the community—the parent, the teacher, the clergyman, and the public official.

Hard Brought Up (Miss/MHMC, 1955, 40 min). Story of a child-welfare worker helping two delinquent boys, their parents, and the community to see the real problems of the boys' behavior and helping to bring about a solution to the problem. Brings in examples of many different child-welfare services.

Who's Delinquent? (RKO/McGraw, 1949, 16 min). The newspaper of a typical American town investigates the causes of juvenile delinquency and shows a meeting of the townspeople in an effort to solve the problem.

Chapter 11. The County Home and Mental Health of the Aged

√ *Adventure in Maturity* (Okla/IFB, 1954, 20 min color). Portrays a woman resigned to a rocking-chair existence who is taught by an older woman friend about opportunities for older women in the community.

Life with Grandpa (MOT/McGraw, 1949, 17 min). Discusses the problems of old age and suggests various remedies for these problems, including constructive efforts to lessen the feelings of loneliness and uselessness.

Make Way for Tomorrow (TFC, 1937, 18 min). An excerpt from the feature film of the same title on indigent old age. Shows the problems created when an elderly widow goes to live with her son's family.

A Place to Live (NSWA/Dynamic, 1955, 24 min). Story of a young family burdened with the care of the wife's ailing father, their decision to place him in a good home for the aged, and the need for community standards for such homes.

Retire to Life (Okla/IFB, 1953, 23 min). Story of a machinist who looked forward to a retirement of fishing and loafing but soon feels useless and unwanted. Emphasizes a positive approach to retirement.

The Steps of Age (MHFB/IFB, 1951, 25 min). Presents the emotional problems and interpersonal relations within the family faced by a woman of 62 who must retire from her job. Emphasizes that one must begin early in life to adjust to the problems of old age.

Chapter 13. Outpatient Services and Residential Care of Mentally Ill Children

Angry Boy (MHFB/IFB, 1950, 32 min). Tells the story of emotional disturbances engendered by family tensions. Tommy, a preadolescent boy, is caught stealing. At a child-guidance clinic, a psychiatric team traces his disturbances to their basic causes and is able to help him.

Face of Youth (Wis U, 1952, 28 min). Story of how parents, nurse, and teacher work together to help two boys with their problems and take the boys to a child-guidance center where, with the help of a therapist, they learn to adjust to their worlds.

Chapter 14. Nonpsychiatric Agencies Serving the Deviant

Back to Life (Pa Welfare/MHMC, 1954, 30 min color or b&w). Shows the care and treatment given a factory worker who has ideas of persecution. Helping him are his wife, minister, social worker, and friends.

A Family Affair (MHFB, 1955, 31 min). Portrays the crises and tensions in a modern marriage and the role of a skilled family counselor in helping resolve them.

A Friend at the Door (CNFB/Seminar, 1950, 28 min). Illustrates the help which can be given by rural social workers to an old-age pensioner, a child in juvenile court, an unmarried mother, and a family distressed by the threat of illness and poverty.

Hard Brought Up. See Chapter 10.

PART THREE—THE PROTECTION OF MENTAL HEALTH

Chapter 15. Public Health and the Prevention of Mental Disorder

√ *Broken Appointment* (MHFB/IFB, 1953, 30 min). Story of a public health nurse who learns that in handling a case successfully, understanding a patient's emotions can be as important as interpreting his physical symptoms.

√ *First as a Child* (Virginia Health/IFB, 1948, 22 min). Case history of a crippled child, from the public health nurse's first visit to his home through diagnosis, treatment, and aftercare. Points out the necessary consideration given to the child's emotional troubles.

White Fortress (CNFB, 1949, 10 min). Shows what Canada's national health program means to a girl who suspects she may have cancer, to a crippled child, and to a young man in need of psychiatric care.

Working for Better Public Health through Recognition of Feelings (USPHS, 1953, 25 min). Shows human-relations situations in public health work, discusses the problems involved, and emphasizes the importance of recognizing feelings of people.

PART FOUR—ELEVATING MENTAL HEALTH

Chapter 16. Positive Mental Health

Psychology for Living (McGraw, 1954). Series of five films correlated with Sorenson and Malm: "Psychology for Living."

1. *Facing Reality* (12 min). Illustrates and explains some common defense mechanisms—rationalization, projection, negativism—and some typical escape mechanisms such as daydreaming, identification, suppression, and malingering.
2. *Successful Scholarship* (11 min). Presents a schedule of good study procedures and routines following a plan-place-method technique and illustrates this method through a portrayal of an average college student.
3. *Habit Patterns* (15 min). Portrays, by contrasting two adolescent girls, the effects of disorderly habits on personality and social life.
4. *Heredity and Family Environment* (9 min). Portrays by pictorial

examples and explains through psychological interpretations the meanings of heredity and environment and their relationship.

5. *Toward Emotional Maturity* (11 min). Portrays an 18-year-old girl faced with a conflict in feelings toward her parents and a boy whom she likes very much, her review of previous incidents involving emotional turmoil, and her realization of the meaning of emotional maturity.

Unconscious Motivation (Hartley/Assn, 1949, 38 min). Shows how unconscious motives can influence and direct everyday thoughts, feelings, and actions; how psychological techniques are used to trace troublesome motives; and the benefits to health resulting from the discovery and release of such unconscious material.

Chapter 17. The Home and the Family

The Family (USIA/UWF, 1952, 20 min). Shows how daily problems of the family are solved when each member understands the needs and desires of others and the family faces its problems together.

Family Circles (CNFB/McGraw, 1949, 31 min). Portrays, through three dramatized situations, the interplay between home and school influences, and how family attitudes affect children's success in school.

Fears of Children (MHFB/IFB, 1951, 30 min). Parent-child situation in which the mother tends to coddle her 5-year-old son and the father expects too much of him. Explains how the conflict magnifies the child's fears.

Head of the House (USIA/UWF, 1953, 40 min). Depicts the emotional problems of a young boy, his rebellion against parental controls, particularly his father's repressive discipline, and his gradual development into a potential juvenile delinquent. Shows the assistance of a community social worker and a neighborhood welfare house in bringing about development of better understanding between father and son.

Know Your Baby (CDHW/Sterling, 1947, 11 min color or b&w). Illustrates methods of care of the new baby. Shows the consideration and understanding necessary until the family adjusts itself to the demands of the newcomer.

The Lonely Night. See Chapter 3.

Marriage for Moderns (McGraw, 1950 and 1954). Series of eight films correlated with Bowman: "Marriage for Moderns."

1. *This Charming Couple* (1950, 19 min). Portrays through dramatized situations a young married couple and the reasons for their failure to achieve marital happiness.
2. *Marriage Today* (1950, 22 min). As a follow-up film to *This Charming Couple,* answers some of the problems raised in the other film. Portrays two couples who have made their marriages work and how the individuals have made a success of their marriages.
3. *Choosing for Happiness* (1950, 14 min). Portrays through dramatized situations the reactions of a girl to various boy friends and her rejection of all of them—and they of her; and suggests that the girl should reevaluate herself and her demands on others.
4. *It Takes All Kinds* (1950, 20 min). Portrays through dramatized sequences a series of young couples reacting to tense situations; relates their reactions to their possibilities for marriage success or failure; and emphasizes the point that marriage partners should be carefully chosen.
5. *Who's Boss?* (1950, 16 min). Portrays a young married couple, both of whom are individualists, their differences, and their decision to adjust their differences through cooperation.
6. *Who's Right?* (1954, 18 min). Dramatization of a quarrel between husband and wife, newly married, caused by her seeing his forcefulness as "bossism" and by his labeling her good taste as extravagance.
7. *Jealousy* (1954, 16 min). Portrayal of a young wife, jealous of her husband, and her gradual realization that her behavior is an expression of her dissatisfaction with her role as homemaker.
8. *In Time of Trouble* (1954, 14 min). Portrays the family minister counseling a young married couple and helping them understand the reasons for their disagreements and ways in which satisfactory adjustments can be made.

Palmour Street (Georgia Health, 1950, 23 min). Shows events in the daily life of Negro families living on Palmour Street in Gainesville, Ga.; illustrates certain basic concepts of mental health as they relate to family life and some of the basic ways in which parents influence the mental and emotional development of their children.

Preface to a Life (USPHS, 1950, 29 min). Parental influence on a child's developing personality, illustrated by a series of episodes showing the effects of an overly solicitous mother and an overly demanding father;

and, in contrast, the healthy childhood resulting when both parents accept their child as an individual.

You and Your Family (Assn, 1946, 8 min). Presents three situations involving parents and adolescents. Gives no solutions but leaves the answers to the audience.

Chapter 19. Mental Hygiene and the School

Activity Group Therapy (Columbia, 1950, 50 min). Film record of a group of emotionally disturbed and socially maladjusted boys undergoing activity group therapy. Shows the gradual improvement in personalities and the role of the therapist.

Counseling Adolescents (McGraw, 1954). Three motion pictures with follow-up filmstrips portraying the work of a student counselor and the psychology involved for counselor and student. Titles are:

A Counselor's Day (11 min)
Using Analytical Tools (14 min)
Diagnosis and Planning Adjustments in Counseling (18 min)

Emotional Health (McGraw, 1947, 20 min). Explains that emotional upsets of college students are common, shows the instances in which professional counsel is needed, and gives some of the methods of psychiatric treatment.

First Lessons (MHFB/IFB, 1952, 22 min). Presents the many problems a teacher is faced with when an aggressive child becomes a member of the class, and shows how a teacher works to overcome these problems.

Guidance Problem for School and Home (TC, 1941, 18 min). Depicts the problem of Danny, a second-grade child who has poor social adjustment and is not doing well in school. Shows how conferences between the teacher and his mother help solve the problem.

Learning to Understand Children. Part 1: A Diagnostic Approach (McGraw, 1947, 21 min). Case study of Ada Adams, an emotionally and socially maladjusted girl of 15, and the efforts of her English teacher to study her case and to understand her; shows some of the diagnostic techniques used.

Learning to Understand Children. Part 2: A Remedial Program (McGraw, 1947, 23 min). A continuation of the case study of Ada Adams in which the teacher develops a plan for remedial action by making use of Ada's talent in art.

Problem Children (ODMH/PCR, 1946, 20 min). Story of two boys in junior-high school and of how their personalities are affected by their relationships in home and school. Illustrates how parents and teachers should work together to provide conditions favorable to the solution of these boys' problems.

The Problem of Pupil Adjustment. Part 1: The Drop-out (McGraw, 1950, 20 min). Flash backs show how frustration of his interests caused a student to lose interest in high school.

The Problem of Pupil Adjustment. Part 2: The Stay-in (McGraw, 1950, 19 min). Explains how a school adjusted its program to meet student needs and interests and thus reduced its drop-out rate.

The Quiet One (Film Doc/Athena, 1948, 67 min). Tells the story of Donald Peters, a mentally retarded Negro boy, who is an only child and the victim of a disrupted home in the Harlem district of New York City, and of his treatment at the Wiltwyck School at Esopus, N.Y.

Who Will Teach Your Child? (CNFB/McGraw, 1948, 24 min). Raises three important questions of the teaching profession and through flash backs presents actual classroom situations in which the teachers cope with day-to-day problems of helping young minds in their development.

Chapter 20. Military Defense Services

Combat Exhaustion (USA, 1945, 50 min). Portrays a colonel in the U.S. Army Medical Corps addressing a group of doctors in the European theater of operations and explaining their responsibilities in treating psychiatric cases, particularly those resulting from combat exhaustion. Shows examples of different types of cases, the administration of drugs to produce a hypnotic state, and the treatment of psychotic patients in the hynotic state.

Combat Psychiatry: The Battalion Medical Officer (USN, 1954, 36 min). Portrays the general run-of-the-mill psychiatric casualties encountered in combat at the battalion level and shows how such casualties are properly managed at this level by the medical officer. Describes the basic and fundamental principles of psychiatry for indoctrinating the medical officer for combat assignment.

Combat Psychiatry: The Division Psychiatrist (USN, 1954, 29 min). Depicts the medical battalion psychiatrist (division psychiatrist) and explains the general principles and practices of combat psychiatry. Points out that cooperation and understanding by the psychiatrist and hospital corps personnel are essential to prevent needless loss of manpower.

Journey to Reality (USA, 1950, 30 min). Portrays through dramatized sequences six patients with typical psychotic reactions entering a hospital; reviews the case histories and outlines appropriate occupational therapy for each patient. Emphasizes the medical officer's responsibility for prescribing and providing occupational therapy.

The N.P. Patient (USN, 1944, 28 min). Shows how to care for and handle neuropsychiatric patients, illustrates typical cases and their treatment, and stresses corpsmen's importance in patients' recovery.

Ward Care of Psychotic Patients (USA, 1945, 44 min). Discusses the duties of ward attendants and methods of caring for psychotic patients in closed wards.

Chapter 21. Mental Health and Work

Condition Improved (CNFB, 1947, 30 min). Account of the contributions of occupational therapy to the successful treatment of victims of physical and mental illnesses.

Date of Birth (CNFB/Seminar, 1950, 16 min). Presents the actual record of employees in the over-45 age group, indicating that they have less absenteeism and a lower turnover rate than younger workers and an equal standard of production.

Employing Blind Workers in Industry (USOE/UWF, 1944, 17 min). Actual instances of blind workers performing jobs in industry; types of work which can be done by blind workers; role of employment specialists in placing and training blind workers.

Employing Disabled Workers in Industry (USOE/UWF, 1946, 20 min). Illustrative examples of disabled workers handling skilled industrial jobs—one-handed milking-machine operator, one-handed machinist, one-armed electric welder, one-handed watch repairman, poliomyelitis-crippled jewelry maker, one-handed secretary.

The Supervisor as a Leader, Part 1 (USOE/UWF, 1944, 14 min). Four dramatized episodes illustrating poor supervisory practices and the importance of the following rules: Always keep promises. Never take credit for someone else's work. Don't pass the buck. Don't play favorites.

The Supervisor as a Leader, Part 2 (USOE/UWF, 1944, 13 min). Four more dramatized instances of poor supervision leading to the following generalizations: Be a leader not an authoritarian. Show appreciation for a job well done. Do not become angry. Protect the rights and feelings of workers.

Chapter 22. Mental Health and Recreation

Recreational and Occupational Therapy (USOE/UWF, 1945, 13 min). Recreational and occupational activities fitted to the patient's condition: passive diversion during an immobile state; limited physical activities carried on in bed; individualized occupational therapy; and social recreation projects.

When All the People Play (CNFB, 1949, 26 min). Shows how a rural district "came alive" under the stimulus of a community recreation program.

Appendix A. Human Growth and Development

Adolescent Development (McGraw, 1953). Series of five films correlated with Hurlock: "Adolescent Development."

1. *The Meaning of Adolescence* (16 min). Points to the unsure status of the adolescent, neither child nor adult, and provides an overview of the social, emotional, mental, and physical changes occurring in the years between childhood and adulthood. Emphasizes the need to help a teen-ager adjust to physical maturity, social living, relations to the opposite sex, problems of religious belief, and conformity to a moral code.
2. *Physical Aspects of Puberty* (19 min). Describes, through animation, the physiological aspects of puberty—primary and secondary sex characteristics, maturation in boys and in girls, variation among individuals, and the emotional and social effects of such variations.
3. *Age of Turmoil* (20 min). Portrays early adolescence, 13–15 years, and the behavior characteristics of giggling, noisiness, criticism of school, daydreaming, and seemingly useless activities. Gives examples of different personality types and of various parent-child situations.
4. *Social-Sex Attitudes in Adolescence* (22 min). Portrays a boy and a girl taken through their entire adolescent experience, their early sex education, awareness of the opposite sex, dating, finding common interests, falling in love, and marrying.
5. *Meeting the Needs of Adolescents* (19 min). Points out, through a study of a family with a 17-year-old girl and a 14-year-old boy, what parents can do to meet the needs of their adolescents.

Answering the Child's Why (EBF, 1951, 13 min). Dramatizes actual situations in which youngsters meet with positive or negative attitudes toward their questions and suggests the resulting effects on their personalities.

Baby Meets His Parents (EBF, 1948, 11 min). Points out how differences in personality can be accounted for, not only by heredity, but also by the human relationships and environmental factors experienced during the first years of life.

Child Development (McGraw, 1950 and 1956). Series of nine films correlated with Hurlock: "Child Growth and Development."

1. *Principles of Development* (1950, 17 min). Outlines the fundamentals of child growth and development and considers the variables which make each child different from every other one.
2. *Child Care and Development* (1950, 17 min). Explains the habits of daily physical care that ensure a happy, healthy child. Covers good habits of eating, sleeping, bathing, the wearing of proper clothing, and outdoor exercise.
3. *Heredity and Prenatal Development* (1950, 21 min). Discusses cell growth and heredity, describes the fertilization of the ovum and traces the development of the fetus until delivery, considers the development of the physical functions of the newborn, and stresses the connection between physical and emotional sensitivity.
4. *Children's Emotions* (1950, 22 min). Discusses the major emotions of childhood—fear, anger, jealousy, curiosity, joy—and points out what the parent can do to lessen fears and promote the child's happiness and natural development.
5. *Social Development* (1950, 16 min). Offers an analysis of social behavior at different age levels and the reasons underlying the changes in behavior patterns as the child develops.
6. *Children's Play* (1956, 27 min). Shows how play differs at various age levels, describes some different forms of play, and emphasizes the need for play time.
7. *Children's Fantasies* (1956, 21 min). Explores the reasons for a child's fantasies and explains how they develop and how children can be affected by them.
8. *Sibling Relations and Personality* (1956, 22 min). Demonstrates through a series of case studies the relationships children have with brothers and sisters during their developmental years.

9. *Sibling Rivalries and Parents* (1956, 11 min). Describes the reasons for rivalry among brothers and sisters, its various manifestations, and parental means of holding natural friction to a minimum.

✓ *Farewell to Childhood* (MHFB/IFB, 1952, 23 min). Dramatized story of a teen-age girl, full of the swift emotions typical of adolescence, longing for and learning the privileges of adulthood. Portrays the adolescent moods of rebellion and trust, anger and irresolution, self-pity, and idealism—and her parents' bewilderment and confusion.

From Sociable Six to Noisy Nine (CNFB/McGraw, 1954, 22 min color or b&w). Portrays characteristic patterns of behavior exhibited by children from 6 to 9 and constructive efforts of parents to understand and guide these children.

The Frustrating Fours and Fascinating Fives (CNFB/McGraw, 1953, 22 min color or b&w). Portrays characteristic patterns of a 4-year-old boy, from imaginative craftsmanship to inconsistent destructiveness, and the changes that occur as he grows into a 5-year-old.

Genetics and Behavior (PCR, 1953, 16 min silent, color or b&w). Documents the thesis that the structure which limits behavior is inherited, but not behavior itself. Showings restricted to professional personnel.

He Acts His Age (CNFB/McGraw, 1949, 15 min color or b&w). Survey of typical behavior patterns of children from ages 1 to 15, demonstrating that as children grow their interests, activities, and emotions change.

Individual Differences (McGraw, 1950, 23 min). Case study of a shy, slow child who is different from his classmates and his older brother. Points out the need to recognize differences among individuals.

Infants Are Individuals (EBF, 1947, 15 min). Demonstrates that individuality and personality are apparent in youngsters from their earliest day. Shows how certain behavior patterns disclosed in infancy persist into later life.

Life Begins (EBF, 1935, 60 min). Pictures 24 years of clinical practice and research on problems of infancy at the Yale University Clinic of Child Development under the direction of Dr. Arnold L. Gesell.

Life with Baby (MOT/McGraw, 1946, 18 min). Shows how children grow mentally and physically. A popular version and condensation of the Gesell Child Development Series.

Life with Junior (MOT/McGraw, 1948, 18 min). Follows Junior through a typical day. Shows in some detail the work of the Child Study Association in America.

Shyness (CNFB/McGraw, 1953, 23 min). Portrays the lonely existence of a shy adult and illustrates the causes of shyness through studies of three children. Explains the reasons for shyness and how this problem may be overcome.

Studies of the Psychoanalytic Research Project on Problems in Infancy (NYU, 1947–1953). Series of 11 films, all but one silent, documenting various aspects of infant behavior.

1. *Anxiety: Its Phenomenology in the First Year of Life* (1953, 20 min)
2. *Birth and the First Fifteen Minutes of Life* (1947, 10 min)
3. *Genesis of Emotions* (1949, 30 min)
4. *Grasping* (1949, 20 min)
5. *Grief* (1947, 30 min)
6. *Motherlove* (1952, 20 min)
7. *Psychogenic Diseases in Infancy: An Attempt at Their Classification* (1952, 20 min)
8. *Shaping the Personality: The Role of Mother-Child Relations in Infancy* (1953, 30 min)
9. *The Smile of the Baby* (1948, 30 min sound)
10. *The Smiling Response* (1948, 20 min)
11. *Somatic Consequences of Emotional Starvation in Infants* (1949, 30 min)

Studies of Normal Personality Development (NYU, 1941–1953). Series of 10 films produced by the Department of Child Study at Vassar College.

1. *Balloons: Aggression and Destructive Games* (1941, 20 min)
2. *Finger Painting* (1941, 22 min color)
3. *Frustration Play Techniques* (1942, 35 min)
4. *A Long Time to Grow. Part 1: Two- and Three-year-olds in Nursery School* (1951, 35 min)
5. *A Long Time to Grow. Part 2: Four- and Five-year-olds in School* (1953, 35 min)
6. *Meeting Emotional Needs in Childhood: The Groundwork of Democracy* (1947, 33 min)
7. *Pay Attention* (1949, 30 min)
8. *Preschool Incidents. Part 1: When Should Grownups Help?* (1951, 13 min)

9. *Preschool Incidents. Part 2: And Then Ice Cream* (1951, 10 min)
10. *Preschool Incidents. Part 3: When Should Grownups Stop Fights?* (1952, 15 min)

The Terrible Twos and Trusting Threes (CNFB/McGraw, 1950, 22 min). A study of child behavior at 2 and 3 years, showing what to expect from youngsters of these ages and suggesting how parents can deal constructively with their problems.

This Is Robert: A Study of Personality Growth in a Pre-school Child (NYU, 1942, 75 min). Traces the development of an aggressive but appealing child from his early nursery school days to his first year in a public school.

Your Children and You (BIS, 1947, 31 min). Concerns the care of young children from the first months to the age of 4 or 5. Offers advice on physical and psychological training.

Your Children's Play (BIS/McGraw, 1952, 20 min). Gives examples of play behavior of 1- to 8-year-olds and emphasizes the need for parents to understand the reasons for such behavior patterns.

Your Children's Sleep (BIS/EBF, 1950, 22 min). Stresses the importance of sound, healthy sleep and advises parents on ways in which they can help secure it for their children.

Appendix B. Psychopathological States—Films for Professional Audiences

Aphasia (USVA, 1950). Series of three films with the following individual titles and running times:

1. *Introduction to Aphasia* (30 min color)
2. *Testing and Individual Therapy for the Aphasic Patient* (28 min color)
3. *Social Adjustment of the Aphasic Patient* (26 min)

A Character Neurosis with Depressive and Compulsive Trends in the Making: Life History of Mary from Birth to Fifteen Years (NYU, 1947, 60 min silent). Film record of a girl with superior biological capacity and an active congenital-activity type who develops, during her 15 years, a neurosis through interaction with those in her environment.

The Feebleminded (PCR, 1942, 41 min). Lists three main classes of causes of feeblemindedness—defective embryonic developments, brain injuries, and interrupted developments. Classifications of feeblemindedness are given in terms of psychological test results and basic psychology.

The Menopause: Its Significance and Management (Schering, 1953, 23 min color). Discusses symptomatology of the syndrome in terms of physiological changes which occur and describes treatment indicated in various clinical cases. Made by W. E. Brown, M.D., for professional audiences.

Mental Symptoms (CNFB/McGraw, 1952). Series of nine films illustrating major psychotic state. Showings restricted to professional or specialized groups.

1. *Schizophrenia: Simple Type Deteriorated* (11 min). Female patient, about 40, exhibits symptoms of simple schizophrenia of 10 years' standing.
2. *Schizophrenia: Catatonic Type* (12 min). Symptoms of stuporous catatonia in three male patients.
3. *Schizophrenia: Hebephrenic Type* (13 min). Interview between a psychiatrist and a male hebephrenic patient hospitalized for 13 years.
4. *Paranoid Conditions* (13 min). Symptoms exhibited by two patients, one with acute and the other with chronic paranoia.
5. *Organic Reaction Type: Senile* (10 min). Interview between a psychiatrist and a man and woman suffering from senile psychoses.
6. *Depressive States, Part 1* (12 min). Shows a middle-aged patient suffering from recurrent depressions.
7. *Depressive States, Part 2* (11 min). Manifestations of retarded depression and of severe depression near the point of attempted suicide.
8. *Manic State* (15 min). Elderly patient exhibits typical hypomanic symptoms during an interview.
9. *Folie à Deux* (15 min). Portrayal of psychotic symptoms in mother and daughter.

Psychotherapeutic Interviewing (USVA, 1950–1952). Series of four films with the following titles and content:

1. *Psychotherapeutic Interviewing: Introduction* (1950, 11 min). Explains the basic principles of the doctor-patient relationship and the structure and goals of the psychotherapeutic interview.
2. *Psychotherapeutic Interviewing: Method of Procedure* (1950, 32 min). Depicts an interview between a patient and a psychiatrist; analyzes the principles and methods employed in the interview; and emphasizes the importance of the doctor-patient relationship, planning

in terms of goals, focusing upon relevant topics, and minimal activity on the part of the doctor.

3. *An Approach to Understanding Dynamics* (1950, 34 min). Depicts an interview between a patient and a psychiatrist, analyzes the dynamics of the interview, and explains the patient's reactions to certain experiences and the meaning of these reactions to the psychiatrist.
4. *Non-verbal Communication* (1952, 27 min). Discusses the recognition of the clues of nonverbal communication and the manner in which these clues can be used in an interview situation to obtain information and to further therapy. Illustrates the various points through pictures, with subtitles, of actual unrehearsed interview situations.

Symptoms of Schizophrenia (PCR, 1938, 18 min silent). Demonstrates symptoms of schizophrenia, fairly typical of those found in psychopathic hospitals, such as social apathy, delusions, hallucinations, hebephrenic reactions, rigidity, etc.

FILM SOURCES

AAMC—American Association of Medical Colleges, 185 N. Wabash St., Chicago 1

Assn—Association Films, Inc., 347 Madison Ave., New York 17

Athena—Athena Films, Inc., 165 W. 46 St., New York 19

BIS—British Information Services, 30 Rockefeller Plaza, New York 20

Brandon—Brandon Films, Inc., 200 W. 57 St., New York 19

CDHW—Canadian Department of Health and Welfare, Ottawa, Ont., Canada.

CNFB—Canadian National Film Board, 1270 Avenue of the Americas, New York 20

Churchill—Churchill-Wexler Film Productions, 801 N. Seward St., Los Angeles 38

Col U—Columbia University Press, Center for Mass Communication, 413 W. 117 St., New York 27

Dynamic—Dynamic Films, Inc., 112 W. 89 St., New York 24

EBF—Encyclopaedia Britannica Films, Inc., 1150 Wilmette Ave., Wilmette, Ill.

Georgia Health—Georgia Department of Health, Atlanta, Ga.

IFB—International Film Bureau, 57 E. Jackson Blvd., Chicago 4
Ind U—Indiana University, Audio-visual Center, Bloomington, Ind.
MHFB—Mental Health Film Board, Inc., 166 E. 38 St., New York 16
MHMC—Mental Health Materials Center, Inc., 1790 Broadway, New York 19
MOT—March of Time, New York (films distributed by McGraw-Hill Book Co., Inc.)
McGraw—McGraw-Hill Book Co., Inc., 330 W. 42 St., New York 36
Miss—Mississippi Department of Welfare, Jackson, Miss.
NAMH—National Association for Mental Health, 13 E. 37 St., New York 16
NSWA—National Social Welfare Assembly, 345 E. 46 St., New York
NYU—New York University Film Library, 26 Washington Pl., New York 3
ODMH—Ohio Division of Mental Hygiene, 1210 State Office Bldg., Columbus, Ohio
Okla—Oklahoma Department of Health, Oklahoma City, Okla.
PCR—Psychological Cinema Register, Pennsylvania State University, University Park, Pa.
Pa Welfare—Pennsylvania Department of Welfare, Bureau of Mental Health, Harrisburg, Pa.
RKO—RKO Radio Pictures, 1270 Avenue of the Americas, New York 4 (films distributed by McGraw-Hill Book Co., Inc.)
Schering—Schering Corp., 2 Broad St., Bloomfield, N.J.
Seminar—Seminar Films, Inc., 347 Madison Ave., New York 17
Sterling—Sterling Films, 205 E. 43 St., New York 3
TC—Teachers College, Columbia University, 525 W. 120 St., New York 27
TFC—Teaching Film Custodians, Inc., 25 W. 43 St., New York 36
USA—U.S. Department of the Army, Washington 25
USIA—U.S. Information Agency, Washington 25 (films distributed in the United States by United World Films, Inc.)
USN—U.S. Department of the Navy, Washington 25
USOE—U.S. Office of Education, Washington 25 (films distributed by United World Films, Inc.)
USPHS—U.S. Public Health Service, Washington 25
USVA—U.S. Veterans Administration, Central Film Library, Washington 25

UWF—United World Films, Inc., 1445 Park Ave., New York 29
Va Health—Virginia Department of Health, Richmond, Va.
Wis U—University of Wisconsin, Bureau of Visual Instruction, 1312 W. Johnson St., Madison 6, Wis.

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